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REPORT
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IMPROVING THE HEALTH STATUS OF NATIVE HAWAIIANS, AND FOR OTHER PURPOSES

OCTOBER 6, 1986.—Ordered to be printed

Mr. ANDREWS, from the Select Committee on Indian Affairs, submitted the following

REPORT

[To accompany S. 2243]

The Select Committee on Indian Affairs, to which was referred the bill (S. 2243) to improve the health status of Native Hawaiians, and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and recommends that the bill as amended do pass.

PURPOSE

The purpose of S. 2243 is to improve the health status of Native Hawaiians through the authorization of programs designed to provide a comprehensive health promotion and disease prevention system of services for Native Hawaiians.

BACKGROUND

The islands that now compose the State of Hawaii were governed by a monarchy of Native Hawaiians until 1893. The Native Hawaiian government was recognized as an independent sovereign nation by foreign governments, and treaty relationships were established with the United States (Treaty of Friendship, Commerce, and Navigation of 1849; Treaty of Commercial Reciprocity, January 30, 1875. As a result of expanded trade with the United States, western influence in the islands increased, and in 1893, the government of Queen Liliuokalani was overthrown in an insurrection engineered by a group of western businessmen in an effort to secure the annexation of Hawaii to the United States. The United States minister in Hawaii ordered one company of marines and two companies

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of sailors to be landed, and the minister then recognized a new provisional government even before Queen Liliuokalani's lines of defense had surrendered. Although the provisional government sought immediate annexation by the United States, President Grover Cleveland refused to submit a treaty of annexation to the Senate, finding that the provisional government lacked the popular support of the Native Hawaiian population and that the government would not have been established but for the lawless and unauthorized military intervention of the United States. Upon the inauguration of William McKinley as the new President of the United States in 1897, however, the western businessmen that sought annexation were able to change the official U.S. position, and in 1898, Hawaii became a territory of the United States.

During the first two decades of the twentieth century, the already depressed economic conditions of Native Hawaiians deteriorated further, and in 1920, the United States Congress legislated directly for the benefit of Native Hawaiians by enacting the Hawaiian Homes Commission Act, and establishing a land base for Native Hawaiians in order to encourage agricultural pursuits. The Act placed approximately 200,000 acres under the jurisdiction of the Hawaiian Homes Commission, a branch of the territorial government for the purpose of "rehabilitating" persons of at least fifty percent Native Hawaiian ancestry through a return to pastoral lie. The Act also authorized the Commission to undertake "activities having to do with the economic and social welfare of the homesteaders."

Hawaii was admitted to statehood in 1959, and the Admission Act transferred the title to the lands of the Hawaiian Homes Commission from the federal government to the state. The state was given administrative powers over the land in return for the state's acceptance of a trust responsibility for administering the lands. The Admission Act, however, retained authority in the Federal government to enforce the trust. The language of the Admission Act requires the state to hold the lands "as a public trust . . . for the betterment of the conditions of Native Hawaiians . . . and their use for any other object shall constitute a breach of trust for which suit may be brought by the United States."

Language contained in Public Law 98-396, 1984 Supplemental Appropriations Act, directed the Department of Health and Human Services to conduct a comprehensive study of the health care needs of Native Hawaiians. The study was conducted under the aegis of Region IX of the Department by a consortium of health care providers and professionals from the state of Hawaii in a predominantly volunteer effort, organized by Alu Like, Inc., a native Hawaiian organization. An island-wide conference was held in November of 1985 in Honolulu to provide an opportunity for members of the Native Hawaiian community to review the study's findings. Recommended changes were incorporated in the final report of the Native Hawaiian Health Research Consortium, and the study was formally submitted to the Department of Health and Human Services in December of 1985. The Department submitted the report to the Congress on July 21, 1986.

STUDY FINDINGS

A report to the Congress on health care needs of Native Hawaiians

The Supplemental Appropriations Act for fiscal year 1984 (Public Law 98-396), directed the Department of Health and Human Services (HHS) to develop a report to the Senate Appropriations Committee containing a comprehensive review of the health care needs of native Hawaiians. The lead for the project was assigned to the Public Health Service (PHS) with the principal action office being the San Francisco Regional Office.

Work on the initial design phase of the project began late in calendar year 1984. The first task was to define the scope and parameters of the health problems of native Hawaiians. The University of Hawaii provided data in February 1985 on mortality and morbidity among native Hawaiians which was used for the Secretary's Task Force on Black and Minority Health. These data revealed that, compared with Caucasians in Hawaii, native Hawaiians have distinctly higher mortality rates for diseases of the cardiovascular system, malignant neoplasms, diabetes, accidents in males and infant mortality. They have lower rates of arthritis and rheumatism and mental and nervous disorders, although in the latter instance, low utilization undoubtedly influences the data.

Based upon the work done by the University of Hawaii, PHS determined that additional study was needed to more fully develop the data base and analyze health care issues among native Hawaiians. Communications with the Native Hawaiian Health Research Consortium (NHHRC), a consortium representing key local organizations focusing on native Hawaiian health issues, were begun in late February 1985 to develop the study approach. The Hawaii State Health Department was represented on the NHHRC. Meetings with NHHRC members in May and June 1985 lead to agreement regarding study methodology, objectives and time frames. Essential elements of the approach included:

Review of data and studies currently available;

Identification of health issues based upon data review and experimential input from NHHRC;

Development of task force reports in four areas: mental health; medical; nutrition/dental; and historical/cultural along with findings and recommendations;

Discussions of the draft task force reports, findings and recommendations at a conference of state and local leaders knowledgeable about native Hawaiian health;

Submission of the final study report, entitled "The Native Hawaiian Health Needs Study" (NHHNS), following a review and comment period by conferees.

Study findings.—The findings of the NHHNS generally conclude that native Hawaiians have significantly more serious health problems than the average resident of the state of Hawaii in the specific areas covered by the study. Significant findings of the four task forces are summarized below:

Mental health.—The mental health task force report concluded that native Hawaiians have higher proportions of: social problems, including assaultive acts and antisocial behavior; alcohol and nar-

cotics use; school performance impairment; suicide among young adults and elderly males; child abuse and neglect; residence in correctional institutions; academic failure and poor school performance; and stress. Native Hawaiians underutilize mental health services they are culturally unacceptable. There is little use of Hawaiian values in mental health treatment programs and virtually no training in Hawaiian culture is provided mental health professionals. The task force found that Hawaiian health beliefs and practices could be used to provide culturally relevant mental health services.

Medical.—The Medical task force concluded that native Hawaiians: have a lower life expectancy due to higher accidental death rates and greater risk of serious illiness: higher infant mortality rates; suffer disproportionately from chronic diseases such as diabetes, heart disease, hypertension, and cancer; have higher cancer rates for cancers of the stomach, lung, and female breast and cervix; have a poorer survival rate from cancer compared with others diagnosed with the same disease; experience heart disease and hypertension at earlier ages; have higher rates of teen pregnancy and illegitimate births; rank highest in having late or no prenatal care, in smoking and alcohol consumption during pregnancy, in toxemia and urinary tract infections during pregnancy and in complications of pregnancy among the over 35 age group; and are less knowledgeable about symptoms and engage in behaviors which are high risk for developing diabetes, heart disease, hypertension, and cancer. Some evidence reviewed by the medical task force also suggests that native Hawaiians receive fewer health services and participate less in health education, health promotion, and screening and referral programs. Native Hawaiians tend to enter medical treatment at the late stages of disease. The major problem in utilization does not appear to be lack of available health service resources, but lack of accessibility, financial barriers and lack of acceptability of services due to cultural barriers.

Nutrition/dental.—The Nutrition/Dental task force found that native Hawaiians: have reduced intake of traditional foods and consume foods high in energy, fats and sugars; have a higher percentage of low birth weight infants; have babies with lower Apgar scores; have poorer diets and consume more alcohol while pregnant; have higher DMF rates; and have high periodontal disease rates and poor dental hygiene.

Historical/cultural.—The Historical/Cultural task force concluded that: historical and cultural health data on native Hawaiians are not adequate; western impact has had a serious negative effect on native Hawaiians; native Hawaiians have not adapted to western economic, social, political and education systems, unlike Asian immigrants; native Hawaiians have embraced some harmful western ways such as use of high fat and sugar foods, tobacco, alcohol and drugs; some traditional values persist such as reverence for nature, love of land, communication with the spiritual realm, group affiliation over individual assertion, avoidance of confrontation, and desire to continue a basic lifestyle; and native Hawaiians must further spiritual and cultural identity and achieve increased political self-determination for improved well-being, including health.

Recommendations

NHHNS recommendations.—The NHHNS places its recommendations for future action to improve native Hawaiian health into the Federal health promotion and disease prevention context. Six component models for an integrated primary care system for native Hawaiians are included: health planning and monitoring; traditional native Hawaiian practice; health research and surveillance; professional health training; health promotion; and primary health care. These models, as in the case of the specific recommendations, recognize the importance of a State, local and Federal partnership to achieve progress in improving native Hawaiian health.

The NHHNS proposes a strategy for achievement of progress on a united front by all concerned levels of government. The NHHNS and its recommendations are recognized as a first step. The basic overriding recommendation of the NHHNS is that a Native Hawaiian Health Planning Advisory Committee be formed to provide leadership at the state level for future implementation actions arising from the NHHNS. This Committee would work closely with all state and local organizations having a role in improving native Hawaiian health and with HHS in those areas where Federal resources can be effectively utilized. The Committee would also designate a lead agency to assist in implementing its policies and decisions.

HHS recommendations.—The data and information contained in the NHHNS confirms the serious health problems facing native Hawaiians. The recommendations contained in the Report accurately focus responsibility for leadership to address these problems at the State and local levels. Resources may be redirected or focussed on the needs of native Hawaiians from amounts currently being provided to the State from Federal and other sources.

The basic recommendation to establish the Native Hawaiian Health Planning Advisory Committee has merit and will be supported by the Department. The Public Health Service Regional Health Administrator in the San Francisco Regional Office will be directed to provide technical assistance and consultation, within currently available resources, to the Committee, if established by the State.

The Regional Health Administrator also will provide assistance to improve the health status of native Hawaiians utilizing Public Health Service programs and resources currently available to the State of Hawaii. To accomplish this objective the Regional Health Administrator will review all Public Health Service funds currently made available to the State, in conjunction with State and local officials, to determine if funds may be re-directed to focus upon the high priority health needs of native Hawaiians.

SUMMARY OF MORTALITY DATA ON NATIVE HAWAIIANS

The following summary of mortality data on Native Hawaiians was prepared at the request of the Committee by the Office of Technology Assessment.

Summary of mortality data on Native Hawaiians

Introduction

"Native Hawaiians" are comprised of two groups: (1) "Hawaiians," or persons identified as being essentially of pure Hawaiian blood, and (2) "Part-Hawaiians," or persons who had at least one parent who had a significant degree of Hawaiian blood. In the period 1980–85, there was an estimated average annual population of 184,841 Native Hawaiians living in Hawaii; 8,134 Hawaiians, and 176,707 Part-Hawaiians. These estimates are derived from the Health Surveillance Program conducted annually by the Hawaii State Department of Health, in which a sample (approximately 6 percent) of the population is surveyed in order to estimate overall population characteristics. As part of this survey, respondents are asked to identify the race or combination of races of their father and mother. If a combination of races is present, respondents are asked to enter only the 3 major ones. Hawaiians are thus represented by respondents with both parents identified as Hawaiian only, and Part-Hawaiians are represented by respondents who have at least one parent with Hawaiian blood.

The Health Surveillance Program is considered the most reliable source for identifying Native Hawaiians. The other major source, the U.S. Census, includes in its designation of "Hawaiian" individuals who self-identified as such or whose parents did so, and did not differentiate between "pure" and "part" Hawaiians. The Census asked all persons (on the "short form") to select the ethnic group which best described them, and also asked some persons (on the "long form") about their ancestry. The 1980 Census counted 118,251 persons who considered themselves Native Hawaiians and 136,341 persons with some degree of Native Hawaiian ancestry living in Hawaii, while the Health Surveillance Program estimate was 175,909.

Mortality data are derived from the Vital Statistics Office of the Hawaii State Department of Health. If a person's race is not known, the racial/ethnic identity of the deceased person's father is apparently listed on the death certificate. Thus, while population estimates from the Health Surveillance Program are generally compatible with mortality data, there will be some degree of undercounting of deaths in the Native Hawaiian population as estimated from the Health Surveillance Program. This means that the mortality data that are presented are somewhat underestimated, but probably not to a degree that would significantly affect the general comparisons presented here between the Native Hawaiian population residing in Hawaii and the U.S. All Races population. In fact, the Native Hawaiian mortality rate is affected more by the use of the Health Surveillance Program's population estimate (175,909 in 1980) instead of the number of persons with some degree of Hawaiian ancestry as derived from the U.S. Census (136,341 in 1980). Thus, if the U.S. Census population estimate had been used, the mortality rates presented here would have been higher.

The actual death rate is obtained by dividing the number of deaths by the number of people, and expressing the result in standard terms, such as the number of deaths per 100,000 persons. However, one of the factors affecting mortality rates is the age distribu-

tion of the population being analyzed. For example, if one population is made up predominantly of older persons while another has a majority of much younger persons and comparisons of the actual mortality rates are made, the older population would have a higher rate, but this would not necessarily mean that the older population was in worse comparative health. We would expect, for example, that more persons in the age group 65 years and older would die in any given year than among an equal number of persons who were between the ages of 25 and 35 years. Thus, a more appropriate comparison would be to calculate age-specific death rates and "adjust" the actual death rates to take into account differences in the age-distribution of the populations being compared. The adjustment of actual death rates is labeled "age-adjusted mortality rates" and is the standard method used when comparing populations (or in following one population over the course of time).

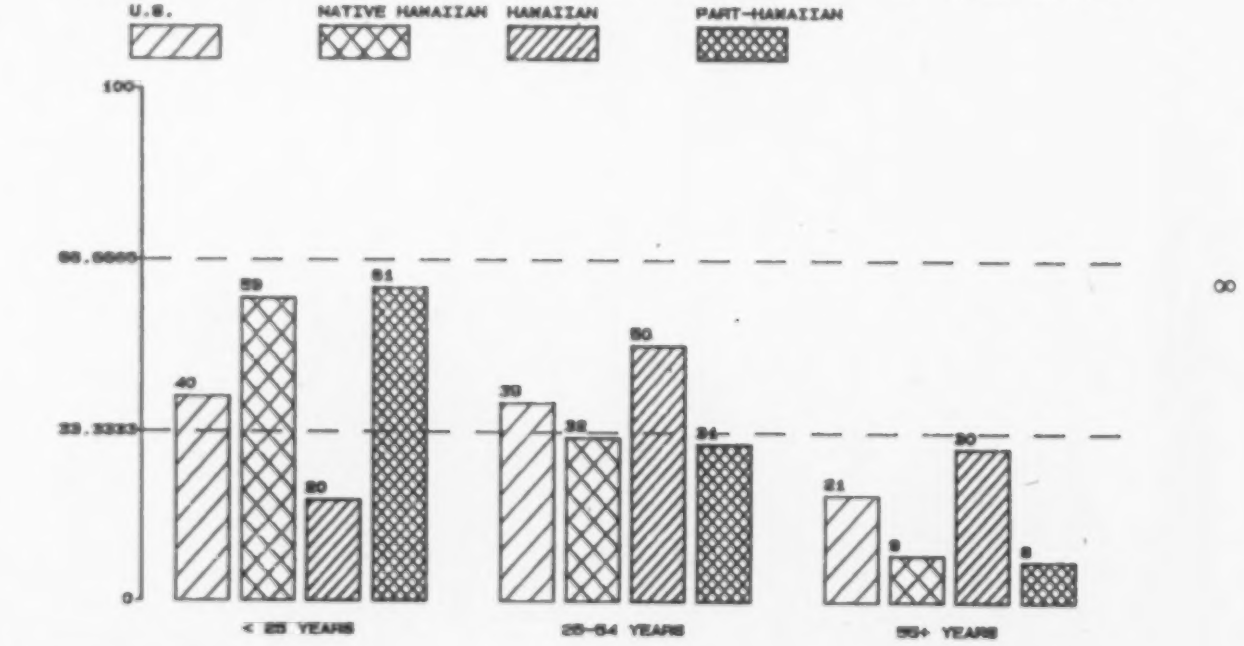
In determining mortality rates for the "U.S. All Races" population, the U.S. National Center for Health Statistics (NCHS) compares yearly changes through the use of age-adjusted mortality rates. The reason is that the U.S. population has grown progressively older, and actual death rates have in turn progressively increased. Without the use of age-adjusted mortality rates, the misleading impression would be that the health of our population is worsening, when in fact it might simply be reflecting the normally higher mortality that accompanies an aging population. Thus, each year, NCHS standardizes its mortality rates by age-adjusting them to a reference population, which is the U.S. population as it existed in 1940. The age-adjusted mortality rates presented here for Native Hawaiians have also been standardized against the reference 1940 U.S. population, which therefore allows a direct comparison with the age-adjusted mortality rates of the U.S. All Races population.

Results

Population

The Hawaiian and Part-Hawaiian populations differ from the U.S. All Races population in their age distributions and mortality rates, and both populations in turn are significantly different from each other in both of these measures. The age distribution of these three populations are summarized in figure 1, and more details of the Hawaiian and Part-Hawaiian populations' age distributions are presented in table 1.

PERCENT DISTRIBUTION BY AGE CATEGORIES FOR US CIVILIAN POPULATION (JULY 1982) AND NATIVE HAWAIIAN, HAWAIIAN AND PART-HAWAIIAN POPULATIONS*



*(YEARLY AVERAGE FOR 1980-1985)

TABLE 1.—AGE-DISTRIBUTION AND PERCENT OF TOTAL OF HAWAIIAN AND PART-HAWAIIAN POPULATIONS (1980–85 YEARLY AVERAGES)

Age bracket	Hawaiian		Part-Hawaiian	
	Number	Percent	Number	Percent
0 to 4	221	2.7	24,558	13.9
5 to 14	468	5.8	43,924	24.9
15 to 24	941	11.6	39,516	22.4
25 to 34	1,160	14.3	27,222	15.4
35 to 44	1,401	17.2	16,401	9.3
45 to 54	1,486	18.3	11,757	6.7
55 to 64	1,150	14.1	7,606	4.3
65 to 74	811	10.0	4,030	2.3
75 and above	496	6.1	1,693	1.0
Total	8,134	[1] 100.1	176,707	[1] 100.2

[1] Total percentages do not equal 100 because of rounding.

Source: State of Hawaii, Department of Health, Health Surveillance Program.

When compared to the U.S. All Races population, the Hawaiian population is significantly older, and the Part-Hawaiin population is significantly younger. Forty percent of the U.S. population was under 25 years of age, compared to 59 percent of the Part-Hawaiian population and only 20 percent of the Hawaiian population. At the other end of the age spectrum, 21 percent of the U.S. population was 55 years or older, compared to 30 percent of the Hawaiian population and only 8 percent of the Part-Hawaiian population.

The principal reason for this age disparity between the Hawaiian and Part-Hawaiian populations is the small size of the Hawaiian population and the diminishing chances that Hawaiians will marry other Hawaiians. In recent years, marriages between Hawaiians and other ethnic groups in Hawaii (including Part-Hawaiians) have hovered around 90 percent of all marriages, while the "outmarriage" rate for Part-Hawaiians has been approximately 50 to 60 percent.

The large number of Part-Hawaiians relative to the number of Hawaiians means that, when both groups are aggregated under the label of "Native Hawaiians," the resulting characteristics will predominantly reflect the characteristics of the Part-Hawaiian population. The estimated average annual population of Hawaiians in 1980–85 was only 8,134, or less than 5 percent of the total Native Hawaiian population of 184,841.

Native Hawaiian mortality

The percent of total deaths and age-adjusted death rates for the 15 leading causes of death among the U.S. All Races population in 1982–83 (the midpoint of the 1980–85 averages calculated for the Native Hawaiian population) are presented in table 2. The leading causes of death among Native Hawaiians are presented in table 3, and table 4 compares age-adjusted death rates for these causes and all causes with the U.S. All Races rates.

TABLE 2.—PERCENT OF TOTAL DEATHS AND AGE-ADJUSTED DEATH RATES FOR THE 15 LEADING CAUSES OF DEATH, UNITED STATES, 1982–83

Rank	Cause of death	Percent of total death [1]	Age-adjusted death rate [1]
	All causes	100.0	552.2
1	Diseases of the heart	38.3	189.7
2	Malignant neoplasms	22.0	132.6
3	Cerebrovascular diseases	7.9	35.1
4	Accidents and adverse effects	4.7	36.0
5	Chronic obstructive pulmonary diseases and allied conditions	3.2	16.8
6	Pneumonia and influenza	2.7	11.4
7	Diabetes mellitus	1.8	9.8
8	Suicide	1.4	11.5
9	Chronic liver disease and cirrhosis	1.4	10.4
10	Atherosclerosis	1.4	4.7
11	Homicide and legal intervention	1.1	9.2
12	Certain conditions originating in the perinatal period	1.1	8.5
13	Nephritis, nephrotic syndrome, and nephrosis	0.9	4.6
14	Congenital anomalies	0.7	5.6
15	Septicemia	0.7	3.2
	All other conditions	11.4	63.7

[1] Subtotals may not equal totals because of rounding.

Source: National Center for Health Statistics, "Advance Report for Final Mortality Statistics, 1982," Monthly Vital Statistics Report 33(9): Supplement, Dec. 20, 1984; "Advance Report for Final Mortality Statistics, 1983," Monthly Vital Statistics Report 34(6): Supplement, Sept. 26, 1985.

TABLE 3.—NATIVE HAWAIIANS LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES), BOTH SEXES

Rank	Cause of death	Number of deaths	Percent of total [1]
1	Diseases of the heart	297	33.4
2	Malignant neoplasms	204	23.0
3	Accidents and adverse effects	55	6.2
4	Cerebrovascular diseases	50	5.6
5	Diabetes mellitus	32	3.6
6	Certain conditions originating in the perinatal period	28	3.2
7	Pneumonia and influenza	21	2.4
8	Congenital anomalies	17	1.9
9	Suicide	17	1.9
10	Other diseases of arteries, arterioles, and capillaries	11	1.2
11	All other infectious and parasitic diseases	10	1.1
12	Homicide and legal intervention	10	1.1
13	Chronic liver disease and cirrhosis	9	1.0
14	Chronic obstructive pulmonary diseases and allied conditions	8	.9
15	Nephritis, nephrotic syndrome, and nephrosis	6	.7
	All other conditions	113	12.7
	Total	[2] 888	99.9

[1] Subtotals may not equal total because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.

Source: State of Hawaii, Department of Health, Research and Statistics Office.

TABLE 4.—NATIVE HAWAIIANS (BOTH SEXES): LEADING CAUSES OF DEATH AND COMPARISON WITH U.S. ALL RACES, BY AGE-ADJUSTED DEATHS PER 100,000 POPULATION, 1980–85 (YEARLY AVERAGES)

Rank	Cause of death	Number of deaths	Age-adjusted death rate [1]		
			Hawaiian	United States	Ratio
	All causes	[2] 888	739.2	552.2	1.34
1	Diseases of the heart	297	273.0	189.7	1.44
2	Malignant neoplasms	204	183.9	132.6	1.39
3	Accidents & adverse effects	55	33.0	36.0	.92
4	Cerebrovascular disease	50	46.1	35.1	1.31
5	Diabetes mellitus	32	29.0	9.8	3.22
6	Certain conditions originating in the perinatal period	28	8.9	8.5	1.05
7	Pneumonia & influenza	21	18.1	11.4	1.59
8	Congenital anomalies	17	6.1	5.6	1.09
9	Suicide	17	9.4	11.5	.82
10	Other diseases of arteries, arterioles, and capillaries	11	9.6	5.3	1.81
11	All other infectious and parasitic diseases	10	8.3	1.6	5.19
11	Homicide and legal intervention	10	6.3	9.2	.68
13	Chronic liver disease and cirrhosis	9	7.7	10.4	.74
14	Chronic obstructive pulmonary disease and allied conditions	8	6.5	16.8	.39
15	Nephritis, nephrotic syndrome and nephrosis	6	5.5	4.6	1.20
	All other conditions	113	87.8	64.5	1.36

[1] Subtotals may not equal totals because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.

Source: State of Hawaii, Department of Health, Research and Statistics Office and Health Surveillance Program; National Center for Health Statistics, "Advance Report for Final Mortality Statistics, 1982," Monthly Vital Statistics Report 33(9) supp., Dec. 20, 1984; "Advance Report for Final Mortality Statistics, 1983," Monthly Vital Statistics Report 34(6) Supp. Sept. 26, 1985.

The two leading and dominant causes of death for both groups were identical—diseases of the heart and malignant neoplasms (cancers). Furthermore, 13 of the 15 leading causes of death were similar for both groups, with the exceptions of "atherosclerosis" and "septicemia" in the U.S. All Races population, and "other diseases of arteries, arterioles, and capillaries" and "all other infectious and parasitic diseases" for the Native Hawaiian population.

The overall death rate, however, was 34 percent higher for Native Hawaiians (table 4), with higher rates for diseases of the heart (44 percent greater), cancer (39 percent greater), cerebrovascular disease (31 percent greater), and diabetes mellitus (222 percent greater). The other comparisons are less reliable because of the small number of yearly deaths among the Native Hawaiian population, but nevertheless provide an indication of where the excess deaths among the Native Hawaiian population are concentrated; i.e., among the five leading causes of death, with the exception of "accidents and adverse effects," for which Native Hawaiians fared slightly better than the U.S. population.

Tables 5 through 8 provide similar information on the Native Hawaiian population by sex. U.S. males have a higher death rate than U.S. females, which is also reflected in the Native Hawaiian population (compare tables 6 and 8). U.S. males also rank higher than U.S. females in traumatic deaths (accidents, suicides, and homicides), and these patterns are also found between Native Hawaiian males and females (compare tables 5 and 7). However, when comparisons are made by sex between Native Hawaiians and U.S. All Races, Native Hawaiian females are relatively worse off than Native Hawaiian males. Native Hawaiian males had a death rate

19 percent higher than U.S. All Races males, whereas Native Hawaiian females had a death rate that was 51 percent higher than U.S. All Races females. This pattern was also reflected in the age-adjusted death rates for specific causes of death, with the exception of suicides, for which Native Hawaiian males had a slightly higher relative rate than females when compared to their U.S. All Races counterparts, although both Native Hawaiian males and females had lower death rates than U.S. All Races males and females (compare tables 6 and 8).

TABLE 5.—NATIVE HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES), MALES

Rank	Cause of death	Number of deaths	Percent of total [1]
1	Diseases of the heart	169	33.6
2	Malignant neoplasms	111	22.1
3	Accidents and adverse effects	40	8.0
4	Cerebrovascular diseases	24	4.8
5	Diabetes mellitus	15	3.0
6	Certain conditions originating in the perinatal period	14	2.8
7	Suicide	14	2.8
8	Pneumonia and influenza	12	2.4
9	Congenital anomalies	9	1.8
10	Homicide and legal intervention	7	1.4
11	Other diseases of arteries, arterioles, and capillaries	6	1.2
11	Chronic liver disease and cirrhosis	6	1.2
13	All other infectious and parasitic diseases	5	1.0
14	Chronic obstructive pulmonary diseases and allied conditions	4	.8
15	Atherosclerosis	3	.6
	All other conditions	64	12.7
	Total	[2] 503	100.2

[1] Subtotals may not equal total because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.

Source: State of Hawaii, Department of Health, Research and Statistics Office.

TABLE 6.—NATIVE HAWAIIANS (MALES): LEADING CAUSES OF DEATH AND COMPARISON WITH U.S. ALL RACES (MALES), BY AGE-ADJUSTED DEATHS PER 100,000 POPULATION, 1980–85 (YEARLY AVERAGES)

Rank	Cause of death	Number of deaths	Age-adjusted death rate [1]		
			Hawaiian	United States	Ratio
	All causes	[2] 503	870.9	729.2	1.19
1	Diseases of the heart	169	328.1	262.4	1.25
2	Malignant neoplasms	111	210.0	164.6	1.28
3	Accidents and adverse effects	40	48.1	54.1	.89
4	Cerebrovascular diseases	24	46.7	38.5	1.21
5	Diabetes mellitus	15	28.0	9.9	2.83
6	Certain conditions originating in the perinatal period	14	9.0	9.4	.96
6	Suicide	14	15.3	18.3	.84
8	Pneumonia and influenza	12	22.6	15.9	1.42
9	Congenital anomalies	9	5.9	5.9	1.00
10	Homicide and legal intervention	7	9.1	14.5	.63
11	Other diseases of arteries, arterioles, and capillaries	6	11.1	8.4	1.32
11	Chronic liver disease and cirrhosis	6	10.5	14.6	.72
13	All other infectious and parasitic diseases	5	9.7	2.0	4.85
14	Chronic obstructive pulmonary diseases and allied conditions	4	6.6	26.3	.25
15	Atherosclerosis	3	6.3	5.5	1.15
	All other conditions	64	103.5	79.3	1.31

[1] Subtotals may not equal totals because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.

Source: State of Hawaii, Department of Health, Research and Statistics Office and Health Surveillance Program; National Center for Health Statistics, "Advance Report for Final Mortality Statistics, 1982," Monthly Vital Statistics Report 33(9): Supp., Dec. 20, 1984; "Advance Report for Final Mortality Statistics, 1983," Monthly Vital Statistics Report 34(6): Supp., Sept. 26, 1985.

TABLE 7.—NATIVE HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES), FEMALES

Rank	Cause of death	Number of deaths	Percent of total [1]
1	Diseases of the heart	128	33.0
2	Malignant neoplasms	93	24.0
3	Cerebrovascular diseases	27	7.0
4	Diabetes mellitus	17	4.4
5	Accidents and adverse effects	15	3.9
6	Certain conditions originating in the perinatal period	14	3.6
7	Pneumonia and influenza	9	2.3
7	Congenital anomalies	9	2.3
9	All other infectious and parasitic diseases	5	1.3
9	Other diseases of arteries, arterioles, and capillaries	5	1.3
11	Nephritis, nephrotic syndrome and nephrosis	4	1.0
11	Chronic obstructive pulmonary diseases and allied conditions	4	1.0
13	Suicide	3	.8
13	Homicide and legal intervention	3	.8
13	Atherosclerosis	3	.8
13	Hypertension with or without renal disease	3	.8
	All other conditions	46	11.9
	Total	[2] 388	100.2

[1] Subtotals may not equal totals because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.

Source: State of Hawaii, Department of Health, Research and Statistics Office.

TABLE 8.—NATIVE HAWAIIANS (FEMALES): LEADING CAUSES OF DEATH AND COMPARISON WITH U.S. ALL RACES (FEMALES), BY AGE-ADJUSTED DEATHS PER 100,000 POPULATION, 1980–85 (YEARLY AVERAGES)

Rank	Cause of death	Number of deaths	Age-adjusted death rate [1]		
			Hawaiian	United States	Ratio
	All causes	[2] 388	622.3	411.4	1.51
1	Dieases of the heart	128	222.9	132.4	1.68
2	Malignant neoplasms	93	160.3	109.7	1.46
3	Cerebrovascular diseases	27	46.2	32.5	1.42
4	Diabetes mellitus	17	29.7	9.6	3.09
5	Accidents and adverse effects	15	18.4	18.8	.98
6	Certain conditions originating in the perinatal period	14	8.7	7.4	1.18
7	Pneumonia and influenza	9	14.4	8.4	1.71
7	Congenital anomalies	9	6.5	5.3	1.23
9	All other infectious and parasitic diseases	5	7.4	1.3	5.69
9	Other diseases of arteries, arterioles, and capillaries	5	8.1	3.1	2.61
10	Nephritis, nephrotic syndrome, and nephrosis	4	7.2	3.8	1.89
11	Chronic obstructive pulmonary disease and allied conditions	4	6.1	10.4	.59
13	Suicide	3	3.5	5.3	.66
13	Homicide and legal intervention	3	3.4	4.0	.85
13	Atherosclerosis	3	4.5	4.2	1.07
13	Hypertension with or without renal diseases	3	4.2	1.6	2.63
	All other conditions	46	70.8	53.7	1.32

[1] Subtotals may not equal totals because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.

Sources: State of Hawaii, Department of Health, Research and Statistics Office and Health Surveillance Program; National Center for Health Statistics, "Advance Report for Final Mortality Statistics, 1982," Monthly Vital Statistics Report 33(9): Supp. Dec. 20, 1984; "Advance Report for Final Mortality Statistics, 1983," Monthly Vital Statistics Report 34(6): Supp., Sept. 26, 1985.

Hawaiian mortality

The 15 leading causes of death among Hawaiians are presented in table 9, and comparisons with the U.S. All Races population are presented in table 10. Because of the small numbers of Hawaiians, only the four leading causes of death averaged more than 10 deaths per year. Nevertheless, these data reflect what has been mentioned earlier; namely, that the mortality data on all Native Hawaiians (tables 3 and 4) principally reflect the data on Part-Hawaiians and mask the data on Hawaiians.

Among the 15 leading causes of death for Hawaiians, "congenital anomalies" and "certain conditions originating in the perinatal period" are replaced by "atherosclerosis" and "hypertension with or without renal disease," which reflects the older Hawaiian population. More importantly, Hawaiians die at a rate 146 percent higher than the U.S. All Races population, compared to an excess death rate for all Native Hawaiians of 34 percent (compare tables 4 and 10). Of the four leading causes of death, Hawaiians when compared to U.S. All Races had rates 177 percent higher for diseases of the heart, 126 percent higher for cancers, 145 percent higher for cerebrovascular disease, and 588 percent higher for diabetes mellitus (table 10).

TABLE 9.—HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES), BOTH SEXES

Rank	Cause of death	Number of deaths	Percent of total [1]
1	Diseases of the heart	87	40.8
2	Malignant neoplasms	48	22.5
3	Cerebrovascular diseases	16	7.5
4	Diabetes mellitus	11	5.2
5	Accidents and adverse effects	7	3.3
5	Pneumonia and influenza	7	3.3
7	All other infectious and parasitic diseases	3	1.4
8	Atherosclerosis	2	.9
8	Chronic obstructive pulmonary diseases and allied conditions	2	.9
8	Other diseases of arteries, arterioles, and capillaries	2	.9
8	Nephritis, nephrotic syndrome, and nephrosis	2	.9
8	Homicide and legal intervention	2	.9
8	Hypertension with or without renal disease	2	.9
14	Chronic liver disease and cirrhosis	1	.5
14	Suicide	1	.5
	All other conditions	20	9.4
	Total	[2] 213	99.8

[1] Subtotals may not equal total because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.

Source: State of Hawaii, Department of Health, Research and Statistics Office.

TABLE 10.—HAWAIIANS (BOTH SEXES): LEADING CAUSES OF DEATH AND COMPARISON WITH U.S. ALL RACES, BY AGE-ADJUSTED DEATHS PER 100,000 POPULATION, 1980–85 (YEARLY AVERAGES)

Rank	Cause of death	Number of deaths	Age-adjusted death rate [1]		
			Hawaiian	United States	Ratio
	All causes	[2] 213	1,357.5	552.2	2.46
1	Diseases of the heart	87	525.1	189.7	2.77
2	Malignant neoplasms	48	299.1	132.6	2.26
3	Cerebrovascular diseases	16	86.1	35.1	2.45
4	Diabetes mellitus	11	67.4	9.8	6.88
5	Accidents and adverse effects	7	76.8	36.0	2.13
5	Pneumonia and influenza	7	35.6	11.4	3.12
7	All other infectious and parasitic diseases	3	15.0	1.6	9.38
8	Atherosclerosis	2	11.7	4.7	2.45
8	Chronic obstructive pulmonary diseases and allied conditions	2	15.4	16.8	.92
8	Other diseases of arteries, arterioles, and capillaries	2	12.1	5.3	2.28
8	Nephritis, nephrotic syndrome, and nephrosis	2	10.2	4.6	2.22
8	Homicide and legal intervention	2	19.4	9.2	2.11
8	Hypertension with or without renal disease	2	9.2	1.8	5.11
14	Chronic liver disease and cirrhosis	1	7.9	10.4	.76
14	Suicide	1	11.8	11.5	1.03
	All other conditions	20	154.7	71.1	2.18

[1] Subtotals may not equal totals because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.

Source: State of Hawaii, Department of Health, Research and Statistics Office and Health Surveillance Program; National Center for Health Statistics, "Advance Report for Final Mortality Statistics, 1982," Monthly Vital Statistics Report 33(9): Supp., Dec. 20, 1984; "Advance Report for Final Mortality Statistics, 1983," Monthly Vital Statistics Report 34(6): Supp., Sept. 26, 1985.

TABLE 11.—HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES), MALES

Rank	Cause of death	Number of deaths	Percent of total [1]
1	Diseases of the heart	52	41.9
2	Malignant neoplasms	28	22.6
3	Cerebrovascular diseases	9	7.3
4	Accidents and adverse effects	5	4.0
4	Diabetes mellitus	5	4.0
6	Pneumonia and influenza	4	3.2
7	Atherosclerosis	1	.8
7	Chronic obstructive pulmonary diseases and allied conditions	1	.8
7	All other infectious and parasitic diseases	1	.8
7	Other diseases of arteries, arterioles, and capillaries	1	.8
7	Homicide and legal intervention	1	.8
7	Suicide	1	.8
7	Chronic liver disease and cirrhosis	1	.8
7	Hypertension with or without renal disease	1	.8
7	Nephritis, nephrotic syndrome and nephrosis	1	.8
	All other conditions	12	9.7
	Total	[2] 124	99.9

[1] Subtotals may not equal total because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.

Source: State of Hawaii, Department of Health, Research and Statistics Office.

TABLE 12.—HAWAIIANS (MALES): LEADING CAUSES OF DEATH AND COMPARISON WITH U.S. ALL RACES (MALES), BY AGE-ADJUSTED DEATHS PER 100,000 POPULATION, 1980–85 (YEARLY AVERAGES)

Rank	Cause of death	Number of deaths	Age-adjusted death rate [1]		
			Hawaiian	United States	Ratio
	All causes	[2] 124	1,711.1	729.2	2.35
1	Diseases of the heart	52	700.5	262.4	2.67
2	Malignant neoplasms	28	363.8	164.6	2.21
3	Cerebrovascular diseases	9	108.8	38.5	2.83
4	Accidents and adverse effects	5	110.9	54.1	2.05
4	Diabetes mellitus	5	63.2	9.9	6.38
6	Pneumonia and influenza	4	40.3	15.9	2.53
7	Atherosclerosis	1	14.8	5.5	2.69
7	Chronic obstructive pulmonary diseases and allied conditions	1	18.1	26.3	.69
7	All other infectious and parasitic diseases	1	12.6	2.0	6.30
7	Other diseases of arteries, arterioles, and capillaries	1	14.5	8.4	1.73
7	Homicide and legal intervention	1	29.1	14.5	2.01
7	Suicide	1	25.7	18.3	1.40
7	Chronic liver disease and cirrhosis	1	12.4	14.6	.85
7	Hypertension with or without renal disease	1	9.0	2.2	4.09
7	Nephritis, nephrotic syndrome and nephrosis	1	7.5	5.8	1.29
	All other conditions	12	179.9	86.9	2.07

[1] Subtotals may not equal total because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.

Source: State of Hawaii, Department of Health, Research and Statistics Office and Health Surveillance Program; National Center for Health Statistics, "Advance Report for Final Mortality Statistics, 1982," Monthly Vital Statistics Report 33(9): Supp., Dec. 20, 1984; "Advance Report for Final Mortality Statistics, 1983," Monthly Vital Statistics Report 34(6): Supp., Sept. 26, 1985.

TABLE 13.—HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES), FEMALES

Rank	Cause of death	Number of deaths	Percent of total [1]
1	Diseases of the heart	35	38.9
2	Malignant neoplasms	20	22.2
3	Cerebrovascular disease	7	7.8
4	Diabetes mellitus	6	6.7
5	Pneumonia and influenza	3	3.3
6	Accidents and adverse effects	2	2.2
6	All other infectious and parasitic diseases	2	2.2
8	Nephritis, nephrotic syndrome and nephrosis	1	1.1
8	Atherosclerosis	1	1.1
8	Hypertension with or without renal disease	1	1.1
8	Other diseases of arteries, arterioles, and capillaries	1	1.1
8	Chronic obstructive pulmonary diseases and allied conditions	1	1.1
8	Homicide and legal intervention	1	1.1
14	Remaining causes average less than 1 case per year		
	All other conditions	9	10.0
	Total	90	99.9

[1] Subtotals may not equal total becuase of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.

Source: State of Hawaii, Department of Health, Reasearch and Statistics Office.

TABLE 14.—HAWAIIANS (FEMALES): LEADING CAUSES OF DEATH AND COMPARISON WITH U.S. ALL RACES (FEMALES), BY AGE-ADJUSTED DEATHS PER 100,000 POPULATION, 1980–85 (YEARLY AVERAGES)

Rank	Cause of death	Number of deaths	Age-Adjusted death rate[1]		
			Hawaiian	United States	Ratio
	All causes	[2] 90	1,081.4	411.4	2.63
1	Diseases of the heart	35	373.6	132.4	2.82
2	Malignant neoplasms	20	238.5	109.7	2.17
3	Cerebrovascular diseases	7	69.0	32.5	2.12
4	Diabetes mellitus	6	70.1	9.6	7.30
5	Pneumonia and influenza	3	32.8	8.4	3.90
6	Accidents and adverse effects	2	55.5	18.8	2.95
6	All other infectious and parasitic diseases	2	19.2	1.3	14.77
8	Nephritis, nephrotic syndrome, and nephrosis	1	12.8	3.8	3.37
8	Atherosclerosis	1	10.6	4.2	2.52
8	Hypertension with or without renal disease	1	9.9	1.6	6.19
8	Other diseases of arteries arterioles, and capillaries	1	10.5	3.1	3.39
8	Chronic obstructive pulmonary diseases and allied conditions	1	14.9	10.4	1.43
8	Homicide and legal intervention	1	10.6	4.0	2.65
14	Remaining causes average less than 1 cases per year				
	All other conditions	9	153.4	72.7	2.11

[1] Subtotals may not equal totals because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.

Source: State of Hawaii, Department of Health, Research and Statistics Office and Health Surveillance Program; National Center for Health Statistics, "Advance Report for Final Mortality Statistics, 1982," Monthly Vital Statistics Report 33(9): Supp., Dec. 20, 1984; "Advance Report for Final Mortality Statistics, 1983," Monthly Vital Statistics Report 34(6): Supp., Sept. 26, 1985.

When death rates are compared for males and females, we find that Hawaiian males died at a rate 135 percent higher than U.S. All Races males (table 12), and Hawaiian females died at a rate 163 percent higher than U.S. All Races females (table 14). As in the case of the overall Native Hawaiian population, Hawaiian females are relatively worse off than Hawaiian males when compared to their U.S. All Races counterparts, and this comparison holds generally for specific causes of death (compare tables 12 and 14).

Part-Hawaiian mortality

The 15 leading causes of death among Part-Hawaiians are presented in table 15, and comparisons with the U.S. All Races population are presented in table 16. The young age of the Part-Hawaiian population is reflected in the high ranking of perinatal conditions (#5) and congenital anomalies (#7) as leading causes of death.

TABLE 15.—PART-HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES), BOTH SEXES

Rank	Cause of death	Number of deaths	Percent of total[1]
1	Diseases of the heart	211	31.4
2	Malignant neoplasms	156	23.2
3	Accidents and adverse effects	48	7.1
4	Cerebrovascular diseases	35	5.2
5	Certain conditions originating in the perinatal period	27	4.0
6	Diabetes mellitus	20	3.0
7	Congential anomalies	17	2.5
8	Suicide	16	2.4
9	Pneumonia and influenza	14	2.1

TABLE 15.—PART-HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES), BOTH SEXES—Continued

Rank	Cause of death	Number of deaths	Percent of total [1]
10	Homicide and legal intervention	8	1.2
10	Other diseases of arteries, arterioles, and capillaries	8	1.2
10	Chronic liver disease and cirrhosis	8	1.2
13	All other infectious and parasitic diseases	7	1.0
14	Chronic obstructive pulmonary diseases and allied conditions	6	.9
15	Nephritis, nephrotic syndrome, and nephrosis	4	.6
	All other conditions	88	13.1
	Total	[2] 673	100.0

[1] Subtotals may not equal total because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.

Source: State Hawaii, Department of Health, Research and Statistics Office.

TABLE 16.—PART-HAWAIIANS (BOTH SEXES): LEADING CAUSES OF DEATH AND COMPARISON WITH U.S. ALL RACES, BY AGE-ADJUSTED DEATHS PER 100,000 POPULATION, 1980–86 (YEARLY AVERAGES)

Rank	Cause of Death	Number of Deaths	Age-adjusted death rate [1]		
			Hawaiian	United States	Ratio
	All causes	[2] 673	645.2	552.2	1.17
1	Diseases of the heart	211	230.1	189.7	1.21
2	Malignant neoplasms	156	162.8	132.6	1.23
3	Accidents and adverse effects	48	30.1	36.0	.84
4	Cerebrovascular diseases	35	38.3	35.1	1.09
5	Certain conditions originating in the perinatal period	27	8.9	8.5	1.05
6	Diabetes mellitus	20	26.6	9.8	2.71
7	Congenital anomalies	17	6.2	5.6	1.11
8	Suicide	16	9.1	11.5	.79
9	Pneumonia and influenza	14	14.7	11.4	1.29
10	Homicide and legal intervention	8	5.6	9.2	.61
11	Other diseases of arteries, arterioles, and capillaries	8	9.2	5.3	1.74
12	Chronic liver disease and cirrhosis	8	7.9	10.4	.76
13	All other infectious and parasitic diseases	7	7.9	1.6	4.94
14	Chronic obstructive pulmonary diseases and allied conditions	6	5.4	16.8	.32
15	Nephritis, nephrotic syndrome, and nephrosis	4	4.4	4.6	.96
	All other conditions	88	78.0	64.2	1.21

[1] Subtotals may not equal totals because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.

Source: State of Hawaii, Department of Health, Research and Statistics Office and Health Surveillance Program; National Center for Health Statistics, "Advance Report for Final Mortality Statistics, 1982," Monthly Vital Statistics Report 33(9): Supp., Dec. 20, 1984. "Advance Report for Final Mortality Statistics, 1983," Monthly Vital Statistics Report 34(6): Supp., Sept. 26, 1985.

TABLE 17.—PART-HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES), MALES

Rank	Cause of death	Number of deaths	Percent of total [1]
1	Diseases of the heart	118	31.1
2	Malignant neoplasms	83	21.8
3	Accidents and adverse effects	36	9.5
4	Cerebrovascular diseases	15	3.9
5	Certain conditions originating in the perinatal period	14	3.7
6	Suicide	13	3.4
7	Diabetes mellitus	10	2.6
8	Congenital anomalies	9	2.4
9	Pneumonia and influenza	8	2.1

TABLE 17.—PART-HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES), MALES—Continued

Rank	Cause of death	Number of deaths	Percent of total [1]
10	Homicide and legal intervention	6	1.6
11	Chronic liver disease and cirrhosis	5	1.3
12	Other diseases of arteries, arterioles, and capillaries	5	1.3
13	All other infectious and parasitic diseases	4	1.0
14	Chronic obstructive pulmonary disease and allied conditions	3	.8
15	Atherosclerosis	2	.5
	All other conditions	49	12.9
	Total	[2] 380	99.9

[1] Subtotals may not equal total because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.

Source: State of Hawaii, Department of Health, Research and Statistics Office.

Part-Hawaiians also died at a rate higher than the U.S. All Races population, but only 17 percent higher. As in the case of the Hawaiian population, diseases of the heart (21 percent higher), cancer (23 percent higher), and diabetes mellitus (171 percent higher) accounted for much of this difference.

When comparisons by sex are made, Part-Hawaiian males turn out to have death rates comparable with U.S. All Races males (table 18), while Part-Hawaiian females have death rates 34 percent higher than U.S. All Races females (table 20, with 34 percent higher rates for diseases of the heart, 48 percent higher for cancer, 29 percent higher for cerebrovascular diseases, and 127 percent higher for diabetes mellitus.

TABLE 18.—PART-HAWAIIANS (MALES): LEADING CAUSES OF DEATH AND COMPARISON WITH U.S. ALL RACES (MALES), BY AGE-ADJUSTED DEATHS PER 100,000 POPULATION, 1980–85 (YEARLY AVERAGES)

Rank	Cause of death	Number of deaths	Age-adjusted death rate [1]		Ratio
			Hawaiian	United States	
	All causes	[2] 380	732.1	729.2	1.00
1	Diseases of the heart	118	267.8	262.4	1.02
2	Malignant neoplasms	83	181.2	164.6	1.10
3	Accidents and adverse effects	36	44.4	54.1	.82
4	Cerebrovascular diseases	15	34.4	38.5	.89
5	Certain conditions originating in the perinatal period	14	9.0	9.4	.96
6	Suicide	13	14.5	18.3	.79
7	Diabetes mellitus	10	22.6	9.9	2.28
8	Congenital anomalies	9	6.0	5.9	1.02
9	Pneumonia and influenza	8	18.6	15.9	1.17
10	Homicide and legal intervention	6	8.2	14.5	.57
11	Chronic liver disease and cirrhosis	5	10.4	14.6	.71
11	Other diseases of arteries, arterioles, and capillaries	5	10.3	8.4	1.23
13	All other infectious and parasitic diseases	4	8.4	2.0	4.20
14	Chronic obstructive pulmonary diseases and allied conditions	3	4.5	26.3	.17
15	Atherosclerosis	2	4.3	5.5	.78
	All other conditions	49	87.5	79.6	1.10

[1] Subtotals may not equal totals because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.
Source: State of Hawaii, Department of Health, Reseach and Statistics Office and Health Surveillance Program; National Center for Health Statistics, "Advance Report for Final Mortality Statistics, 1982," Monthly Vital Statistics Report 33(9) Supp., Dec. 20, 1984; "Advance Report for

Final Mortality Statistics, 1983," Monthly Vital Statistics Report 34(6): Supp., Sept. 26, 1985.

TABLE 19.—PART-HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES), FEMALES

Rank	Cause of death	Number of deaths	Percent of total[1]
1	Diseases of the heart	93	31.0
2	Malignant neoplasms	73	24.3
3	Cerebrovascular diseases	20	6.7
4	Certain conditions orginating in the perinatal period	14	4.7
5	Accidents and adverse effects	13	4.3
6	Diabetes mellitus	11	3.7
7	Congenital anomalies	9	3.0
8	Pneumonia and influenza	6	2.0
9	Other diseases of arteries, arterioles, and capillaries	4	1.3
9	Chronic obstructive pulmonary diseases and allied conditions	4	1.3
11	All other infectious and parasitic diseases	3	1.0
11	Suicide	3	1.0
11	Nephritis, nephrotic syndrome and nephrosis	3	1.0
11	Chronic liver disease and cirrhosis	3	1.0
11	Homicide and legal intervention	3	1.0
	All other conditions	38	12.7
	Total	[2] 300	100.0

[1] Subtotals may not equal total because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.

Source: State of Hawaii, Department of Health, Research, and Statistics Office.

TABLE 20.—PART-HAWAIIANS (FEMALES): LEADING CAUSES OF DEATH AND COMPARISON WITH U.S. ALL RACES (FEMALES), BY AGE-ADJUSTED DEATHS PER 100,000 POPULATION, 1980–85 (YEARLY AVERAGES)

Rank	Cause of death	Number of deaths	Age-adjusted death rate[1]		
			Hawaiian	United States	Ratio
	All causes	[2] 300	553.0	411.4	1.34
1	Disease of the heart	93	196.0	132.4	1.48
2	Malignant neoplasms	73	146.2	109.7	1.33
3	Cerebrovascular diseases	20	42.0	32.5	1.29
4	Certain conditions originating in the perinatal period	14	8.8	7.4	1.19
5	Accidents and adverse effects	13	16.0	18.8	0.85
6	Diabetes mellitus	11	21.8	9.6	2.27
7	Congenital anomalies	9	6.5	5.3	1.23
8	Pneumonia and influenza	6	11.4	8.4	1.36
9	Other diseases of arteries, arterioles, and capillaries	4	7.8	3.1	2.52
9	Chronic obstructive pulmonary diseases and allied conditions	4	6.0	10.4	.58
11	All other infectious and parasitic diseases	3	5.4	1.3	4.15
11	Suicide	3	3.8	5.3	.72
11	Nephritis, nephrotic syndrome, and nephrosis	3	6.0	3.8	1.58
11	Chronic liver disease and cirrhosis	3	5.4	6.7	.81
11	Homicide and legal intervention	3	2.4	4.0	.40
	All other conditions	38	67.6	52.8	1.28

[1] Subtotals may not equal totals because of rounding.
[2] Male and female totals calculated separately any may not equal total for both sexes.

Source: State of Hawaii, Department of Health, Research and Statistics Office and Health Surveillance Program; National Center for Health Statistics, "Advance Report for Final Mortality Statistics, 1982," Monthly Vital Statistics Report 33(9): Supp., Dec. 20, 1984; "Advance Report for Final Mortality Statistics, 1983," Monthly Vital Statistics Report 34(6): Supp., Sept. 26, 1985.

Summary

The Native Hawaiian population living in Hawaii consists of two groups, Hawaiians and Part-Hawaiians, who are distinctly different in both age distributions and mortality rates. Hawaiians comprise less than 5 percent of the total Native Hawaiian population and are much older than the young and growing Part-Hawaiian population.

Overall, Native Hawaiians have a death rate that is 34 percent higher than the death rate for U.S. All Races, but this figure masks the great differences that exist between Hawaiians and Part-Hawaiians. Hawaiians have a death rate that is 146 percent higher than the U.S. All Races population, while Part-Hawaiians also have a higher rate, but only 17 percent greater than the rate for the U.S. All Races population. A comparison of the age-adjusted death rates for Hawaiians and Part-Hawaiians reveals that Hawaiians die at a rate 110 percent higher than Part-Hawaiians, and this pattern persists for all except one of the 13 of 15 leading causes of death that are common to both groups (table 21).

TABLE 21.—COMPARISON OF AGE-ADJUSTED DEATH RATES FOR HAWAIIANS AND PART-HAWAIIANS (BOTH SEXES) BY SELECTED LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES)

Cause of death	Age-adjusted death rates [1]		
	Hawaiians	Part-Hawaiians	Ratio
All causes	1,357.5	645.2	2.10
Diseases of the heart	525.1	230.1	2.28
Malignant neoplasms	299.1	162.8	1.84
Diabetes mellitus	67.4	26.6	2.53
Cerebrovascular diseases	86.1	38.3	2.25
Other diseases of arteries, arterioles, and capillaries	12.1	9.2	1.32
Nephritis, nephrotic syndrome, and nephrosis	10.2	4.4	2.32
Accidents and adverse effects	76.8	30.1	2.55
Suicide	11.8	9.1	1.30
Homicide and legal intervention	19.4	5.6	3.46
Pneumonia and influenza	35.6	14.7	2.42
All other infectious and parasitic diseases	15.0	7.9	1.90
Chronic obstructive pulmonary diseases and allied conditions	15.4	5.4	2.85
Chronic liver disease and cirrhosis	7.9	7.9	1.00

[1] Subtotals may not equal totals because of rounding.

Source: State of Hawaii, Department of Health, Research and Statistics Office and Health Surveillance Program.

As in the case of the U.S. All Races population, Hawaiian and Part-Hawaiian males have higher death rates than their female counterparts. However, when Hawaiian and Part-Hawaiian males and females are compared to their U.S. All Races counterparts, females are found to have more excess deaths then males. Most of these excess deaths are accounted for by diseases of the heart and cancers, with lesser contributions from cerebrovascular diseases and diabetes mellitus.

Diseases of the heart and cancers account for more than half of all deaths for the U.S. All Races population, and this pattern is also found in both the Hawaiian and Part-Hawaiian populations, whether grouped by both sexes or by male or female. However, Hawaiians and Part-Hawaiians have significantly higher death rates than U.S. All Races for these two major diseases, with the excep-

tion of Part-Hawaiian males, for whom the death rate from all causes is approximately equal to that of U.S. All Races males.

One disease that stands out is diabetes mellitus, for which even Part-Hawaiian males have a significantly higher death rate than U.S. All Races males. Overall, Native Hawaiians die from diabetes at a rate that is 222 percent higher than U.S. All Races. When compared to their U.S. All Races counterparts, deaths from diabetes mellitus range from 630 percent higher for Hawaiian females and 538 percent higher for Hawaiian males, to 127 percent higher for Part-Hawaiian females and 128 percent higher for Part-Hawaiian males.

SUMMARY OF MAJOR PROVISIONS

S. 2243 provides authority for the establishment of a health promotion and disease prevention program that would inlcude authority for the provision of direct health care services to Native Hawaiians, health education, medical and mental health research, and data collection. Subject to additional appropriations being made available, the establishment of community health centers to address the health care needs of Native Hawaiians is authorized under the existing authority of section 330 of the Public Health Service Act. Also, subject to additional appropriations being made available, scholarship assistance to Native Hawaiians entering the health care professions is authorized under the existing authority of the National Health Service Corps program in the Public Health Service Act. That program currently requires a pay-back obligation for all scholarship recipients through service in the Public Health Service commensurate with the number of years for which scholarship assistance is received. The bill also provides autority for the Secretary of Health and Human Services to enter into contracts with Native Hawaiians organizations for the provision of health care referral service to Native Hawaiians, to encourage and increase Native Hawaiian access and utilization for existing health care resources. The programs proposed for authorization in S. 2243 are to be administered directly by the U.S. Public Health Service within the Department of Health and Human Services, and do not entail any program activity on the part of the Indian Health Service nor any funding from the IHS account within the Department.

ANALYSIS OF THE LEGAL RELATIONSHIP BETWEEN THE FEDERAL GOVERNMENT AND NATIVE HAWAIIANS

The following analysis of the legal relationship between the United States government and Native Hawaiians was prepared at the request of the Committee:

Summary

The Federal Government has a trust relationship to Native Hawaiians. The relationship is premised on the course of dealings of the United States and its citizens with Native Hawaiians and their government, the explicit recognition of the relationship by the United States Congress in establishing the Native Hawaiian Home Lands Commission, and the recognition by the federal courts of the relationship. While most commentators agree that a trust relation-

ship exists, there is little agreement as to the exact nature of any obligations that may be implicit in acknowledging such a relationship. It is probable that unless Hawaiian Native issues are addressed on a more comprehensive basis, such as they have been to some extent for many Indians and Alaskan Natives, the extent of the trust relationship for Native Hawaiians will remain unsettled. What is clear, however, is that Congress does possess the authority, pursuant to the Federal Native Hawaiian relationship to enact legislation that is rationally related to the purposes of the trust relationship—to legislate for the benefit of native Hawaiians.

Services and the Federal-Indian relationship

A key concept of the Federal-Indian Relationship is the Federal trust responsibility. In two related cases, *Cherokee Nation v. Georgia*, 30 U.S. (5 Pet.) 1 (1831), and *Worcester v. Georgia*, 31 U.S. (6 Pet.) 515 (1832), Chief Justice John Marshall described Indian tribes as "domestic dependent nations" and characterized the relationship of the United States to the Indian tribes as one that "resembles that of a ward to his guardian." The responsibility to deal with Indians was constitutionally assigned to the Federal Government. This responsibility has become universally known as "the trust relationship." It is important to note that the responsibility has never been fully defined. Because a concrete definition of the trust responsibility might fail to take into account changing conditions and changing needs, the relationship can be described but not defined with any exactness. Some commentators define the trust as the responsibility that the Federal Government assumes from the operation of International law, the constitution, treaties and practice for the property and the well-being of Indian people.[2]

There are both mendatory and permissive aspects of the trust reltionship. Because of the Federal-Indian relationship, the U.S. must exercise certain fiduciary standards with respect to Indian property. The existence of the relationship is also the basis for the provision of services that are not necessarily mandatory. The difference between what is a trust right and what is a trust-based service, often the subject of hard fought political and legal battles, is only occasionally a key issue in the actual delivery of services.[3] In what can be labeled the "trust mandated" or trust right situation, the beneficiaries can hold the trustee accountable, either in terms of monetary damages or equitable enforcement. In what can be termed the trust-based situation, Congress can provide distinct services to Indians; services that are insulated from challenge under the equal protection standards of the fourteenth amendment and similar standards incorporated in the fifth amendment to the Constitution.[4] Although Indians may not be able to require the United States to maintain a particular service or to provide damages for its withdrawal, in the trust-based situation, the existence of the trust does require that certian due process procedures be followed with respect to those services.[5]

Some argue that many of the social services that are provided, such as health and education, are services mandated by the trust responsibility. The Executive Branch often argues that most Indian services are at best premised on the trust responsibility but are not

required (trust-based). It argues that only services associated with trust property are the "true" trust services. Congress which constitutionally has the power to determine the extent of the trust, generally avoids the issue of determining whether any particular service is required by the trust relationship.[6] These issues are only infrequently addressed by the Courts, and when they are, they come up in unique factual situations, so that the issue of what services are trust rights or simply trust based is likely to remain unsettled. However, it is clear under *Morton* v. *Mancari* that in order for a program to exist it need only be rationally tied to United States' trust obligation.

There is a third class of services to which Indian tribes and people have access. These generally are services that are created by Congress to meet a defined social need and Indians are included as one of the many beneficiary groups. Although the trust relationship provides the basis for defining Indians as an eligible class in the general legislation, analytically such programs are neither trust mandated services, nor strictly speaking services based on the trust responsibility.

Unless Congress clearly establishes that a particular service is a right under the trust relationship, most federal services provided to Hawaiian Natives would seem to fall within the other permissible categories of services.

The basis of the Federal-Hawaiian Native relationship

Most commentators and courts that have explored the question of the Federal-Hawaiian Native trust relationship have concluded that although the perimeters are not defined, as they are also not defined for Indians, such a trust relationship exists.[7] It is based on the dependency of the indigenous Hawaiian Natives, and the recognition by the United States Congress of that status in the annexation of Hawaiian Islands, the establishment of the Hawaiian Homes Commission, and the Hawaiian Admissions (statehood) Act.

Felix Cohen's Handbook on Federal Indian Law [8] is the most prestigious and comprehensive treatment in the field. The 1982 edition says of Native Hawaiians:

> * * * they are a people indigenous to the United States * * * however * * * they have not been dealt with comprehensively by Congress.
>
> * * * * *
>
> * * * the full extent of the trust obligation owed by the United States to Native Hawaiians and the manner of its fulfillment has not been fully defined.[9]

The Congressional Research Service in response to a request from Senator Daniel K. Inouye reviewed the question and concluded:

> The courts have upheld the power of Congress to single Indians out for special treatment because of their unique status under the Constitution and treaties, and have inferred a trusteeship obligation on the part of the United States toward the aboriginal people that constitute the

> original inhabitants of lands now within the borders of the continental United States. * * * The same reasoning that was used to infer a trust relationship between the United States government and the Indian tribes would seem to be capable of being applied to the relationship with Native Hawaiians.[10]

Several federal courts and the Supreme Court of Hawaii have had to address the issue of whether a trust relationship exists and all have concluded that it does. Perhaps the most misunderstood case in the area is *Keaukaha-Pananewa Community Association* v. *Hawaiian Homes Commission,*[11] known as *Keaukaha I.* This case considered whether a group of Native Hawaiians had standing as private parties to bring suit in federal court under the Hawaiian Homes Commission Act and/or the Hawaiian Admissions Act to prevent the Commission from transferring certain trust lands. Although the Court was clear that a trust for the benefit of Native Hawaiians had been established by these Acts, the administration of which was primarily with the state of Hawaii, the Court determined that a Federal question did not exist and that state court was the proper forum. In reaching that conclusion the 9th Circuit stated:

> It is clear, however that for all practical purposes these benefits have lost their federal nature.[12]

It has been suggested that this dicta of the 9th Circuit may be a barrier to asserting a Federal-Hawaiian Native Trust relationship. The statement should be understood in the context of *Keaukaha I* being a case pertaining to availability of remedies, not a definition of rights. Rights and remedies do not necessarily run together. It is quite clear in Indian law that many Indian "rights" have been what Justice Frankfurter once termed "hortatory" and required special acts of Congress to permit vindication of those rights.[13] The fact that a number of Indian rights currently require remedies in State forums rather than Federal forums does not convert the Federal Indian right into a State right.[14] A more recent case covering the identical underlying factual issues and parties, known as *Keaukaha II*[15] determined that Native Hawaiians had a federal right enforceable under the 42 U.S.C. 1983, a reconstruction era civil rights statute. This decision should end any confusion over Hawaiian rights that remained under *Keaukaha I.* Section 1983 actions are premised on the deprivation under the color of state law of a federal right. The Federal right required for the application section 1983 is the finding that the Hawaiian Admissions Act clearly "mandates the establishment of a trust for the betterment of native Hawaiians."

The Supreme Court of Hawaii in *Ahuna* v. *Department of Hawaiian Home Lands,* 64 Haw. 327, 640 P. 2d 1161 (1982) also has addressed the issue of Federal-Hawaiian Native Trust relationship in order to determine the obligations of the Department of Hawaiian Home Lands. The Court determined that: (1) the legislative history of the Hawaiian Homes Commission Act indicates that the United States "stood in a trusteeship capacity to the aboriginal people" of Hawaii; and (2) the primary purpose of the Act "was the rehabilita-

tion of native Hawaiians". The Hawaiian Supreme Court then utilized Federal-Indian law to determine the state agency's fiduciary obligation, as the instrumentality for effectuating the Federal purpose.

THE HISTORICAL RELATIONSHIP

A review of the history of relations between Hawaiian Natives and the United States demonstrates that there are significant parallels to aspects of U.S.-Indian history and gives credence to the observations of the commentators and the Courts.

It has been estimated that approximately 300,000 native people occupied the "Sandwich Islands", as Hawaii was then called when Western society discovered them in 1778. The indigenous Hawaiians had a complex political and economic but self-sufficient system in existence at time of contact. The system has been compared to the feudal system of medieval Europe. Private property—fee simple title—did not exist. Land occupancy rights ran from greater lords to lesser lords to commoners; obligations ran in reverse order.[16] Each island was autonomous until 1810 when Kamehameha I united the Islands by conquest and negotiation.

Certain similarities to the Indian situation at the time of discovery are pertinent. Both populations were politically autonomous, and both populations were self-sufficient in their traditional economies and life styles. Neither population had a private property system; but they did however control most, and in some cases all, of the lands within their political boundaries.

All of these situations would change. The various ways that Indians lands have been alienated from Indian ownership has been documented in proceedings of the Indian Claims Commission, and other sources. Interestingly, treaties which have become a major source of evidence in establishing a trust relationship, were often the instruments of land loss. The role of the United States in these transactions was fairly clear; it either directly obtained the Indian land or failed to protect the tribes in their land dealings.

The role of the United States in the Hawaiian loss of land was different in form than in the Indian situation but just as central. Treaties with the Native Hawaiian government were not land transactions but were means of assuring commercial access. The first treaty of peace and friendship proposed in 1826 was not ratified by the United States.[17] The first ratified treaty (1849)[18] dealt with friendship, commerce and navigation. A second treaty was entered into in 1875; dealing with commercial reciprocity.[19] A final treaty, also concerning commercial reciprocity was entered into in 1884.[20] Throughout the 19th century, it would be the American merchants along with American missionaries who under the auspices of "civilizing" a system they felt was culturally inferior to their own would intervene with the military support of the United States government in internal Hawaiian affairs, beginning with the western style constitution of 1840 and ending in an insurrection against the Hawaiian monarchy.

During the first half of the 19th century, the merchants were supported by their respective Governments (French, British and American) by the use of naval war ships.[21] In effect the Western-

ers, and eventually the United States, using the threat of military force reduced the Kingdom of Hawaii to the functional equivalent of a dependent sovereign—a suzerainty.

The influence of the western powers was greatly felt in the land system:

> By 1845, the land tenure system could neither maintain itself in the face of a hostile foreign world or accommodate itself to the wishes of that world.[22]

A land Commission dominated by Westerners was appointed. It would oversee the "Great Mahele"; the end of the traditional Hawaiian land system and the substitution of a western style system of fee ownership. Cohen points out that:

> By destroying the interlocking communal nature of land tenure its [the Great Mahele] effect was similar to allotment and termination acts on the mainland.

Land rights were concentrated in the hands of the very few. The King and the chiefs held title to 99 percent of all the lands. In a process not dissimilar to that which occurred with Indian lands after allotment, title to much of land was soon transferred to Non-Hawaiian ownership. Large plots of lands owned by royalty no longer had communal obligations attached and were therefore not productive without western capital or management systems. They were sold off at "distress prices" and fraud was not uncommon; ultimately a plantation economy with imported non-Hawaiian labor was established. Small plots were also uneconomical and most were soon lost.

All commentaries seem to agree that in the second half of the 19th Century a small number of Westerners (2000) came to control most of the land in Hawaii:

> Native Hawaiians had been excluded from the mainstream of the economy; they had lost ownership of most privately held land and had been reduced to a minority of the inhabitants of the Kingdom.[23]

Control of land, however, was not enough. The Westerners who by the latter part of the nineteenth century were primarily Americans, sought political control. As noted previously the first Hawaiian constitution of 1840 was procured by western influence. The constitution of 1887, known as the "Bayonet Constitution" was forced on the Monarchy by armed merchants—American citizens. This constitution restricted the right to vote to those who paid taxes, including non-citizens. Native Hawaiians were disenfranchised and the American merchants obtained a virtual dictatorship. The last royal ruler of Hawaii, Queen Liliuokalani, came to the throne in 1892 and attempted to replace the "Bayonet constitution" with a new one that would have significantly eroded western power. Foreigners were to be precluded from obtaining citizenship or from voting. In January 1893, shortly before the new constitution was to go into effect, and while President Harrison, who favored annexation, was still in office, armed American merchants, aided by the U.S. minister in Hawaii, John L. Stevens, and marines from the U.S.S. Boston forced the Queen to relinquish her govern-

mental authority. A provisional government dominated by American merchants was established. The government immediately sought annexation by the United States. The goal of annexation, however, would take a few years. Assuming office shortly after the overthrow of the Queen, President Cleveland, supported by the Blount report [24] refused to support annexation.[25] The Blount Report found that the overthrow of the Queen had been illegal; and recommended that she be restored to power. The Provisional government of Hawaii refused to follow Blount's recommendations and instead established the Republic of Hawaii. The Republic thereupon took over all crown or public lands without compensation.

Another report on annexation would be prepared by the Senate Foreign Relations Committee, known as the Morgan Report.[26] It approved the United States support of the merchants. It used a familiar theory . . . determining Hawaii to be a dependent sovereignty of the United States. An analogous theory to that used in the landmark decisions that gave judicial recognition to the Federal-Indian relationship, *Worcester* and *Cherokee Nation.* The report stated:

> [It] is a recognized fact that Hawaii has been all the time under a virtual suzerainty of the United States . . . a de facto supremacy over the country.

A "suzerainty" was understood in International law to be the relationship that a more powerful sovereign has over a dependent one; the dependent sovereign was usually viewed as less "civilized" than the powerful sovereign.

After the Morgan Report, by a joint resolution of Congress the United States annexed Hawaii in 1898.[27] Cohen states that with annexation "Native Hawaiians became a dependent indigenous people of the United States." [28]

Native Hawaiian conditions which were difficult at the time of annexation continued to deteriorate. Indian conditions were at some time also suffering from similar circumstances; loss of traditional life styles and food resources; loss of the native land base; and destruction of traditional modes of self-government. By the 1920's, reformers were concerned about the conditions of Native people. For Indians, the Red Cross survey of conditions, and the Meriam Commission report would result in a partial reversal of many of the policies of the 19th century.

For Hawaiian Natives the concern would focus in the Hawaiian Homes Commission Act.[29] The Act set aside 200,000 acres of land to be leased to Native Hawaiians for 99 years at nominal rates. Congress viewed the Hawaiian Homes Commission as a "plan for the rehabilitation of the Hawaiian Race." The bill was introduced by the nonvoting Delegate from Hawaii, J. K. Kalanianole, a member of the royal family of Hawaii based on a plan developed by Senator Wise. Hawaiians were thought to be a dying race, numbering a scant 22,500 in 1920. The House Committee Report [30] on the Homes Commission quotes from the hearing record to establish the cause of the problem it was attempting to remedy.

> Mr. MONAHAN. What caused this dying away of the race * * *

> Secretary [of the Interior] LANE. * * * It is always incident to the comings of civilization and we always carry disease germs with us to which these people are not immune * * *

The Committee's response to any challenge to the bill's constitutionality as "unconstitutional class legislation" was to point out, among other arguments, that Congress had the authority to provide special benefits for unique groups such as "Indians, soldiers and sailors . . .". This is the same argument in embryonic form, that the Supreme Court would later use in *Morton* v. *Mancari* to sustain special programs for Indians. This statute is universally viewed as Congress' recognition of the special relationship the United States has to Native Hawaiians.

When Hawaii became a state in 1959, the dominant federal-Indian policy was then the termination of Indian reservations and the transfer of much Federal administrative responsibility to States. It is therefore not surprising that the Hawaiian Homes Commission was made part of the responsibilities of the state of Hawaii upon Hawaii's admission to the union. Since the rights involved were Federal, Federal responsibility was retained. Any changes proposed by the State that could impair Hawaiian Native rights require Congressional consent, and the United States is the only party with specific standing to sue in Federal courts to enforce the provisions of the trust.[31]

Since statehood Congress has periodically legislated for the benefit of Native Hawaiians.[32] It has not, however, comprehensively addressed Hawaiian Native issues. This situation is not entirely different from the Federal-Indian relationship, which also has not been comprehensively spelled out. Many of the Indian programs are premised on general statutory authority. The Executive branch has been allowed great latitude in defining the nature and scope of programs.[33] Absent an express direction from Congress, the agencies operating federal programs have not included Hawaiian Natives. Although it is possibly administratively feasible to include Hawaiian Natives, given the broad discretion asserted by federal agencies, inclusion of the Hawaiian Native population in federal program by agency action is not very likely. Department of Interior regulations on tribal recognition apply only in the continental United States and therefore exclude Hawaiians.[34] Furthermore most agency activity in the last decade has focused on reducing beneficiaries by narrowing eligibility criteria.

In many ways, native Hawaiian issues resemble those of Native Alaskans prior to the Alaskan Native Claims Settlement Act. In addressing the issue of whether "Eskimos" were "Indians" even though not of the same racial origin, courts have determined that the term "Indians" is not a racial classification but a term of art for the aboriginal peoples of America.[35] "Alaskan natives were sometimes included in Indian programs, although not always. Periodically programs were passed for Alaskan Natives that did not have Indian counterparts.[36] Alaskan Natives with several exceptions did not have reservations or trustlands. In addition to resolving Alaskan land claims, the Settlement Act provided for a comprehensive definition of Alaskan natives, and the creation of a series

of entities, including existing traditional Native villages, as the mechanisms for land holding as well as service delivery. These mechanisms which have no counterpart in Indian affairs in the lower-forty eight states, but have become routine parts of the Federal-Alaska Native relationship.

Many distinct issues, and many divergent views exist on the subject of Hawaiian Lands Claims. Absent such a comprehensive approach to Hawaiian issues, as was provided for Alaskan Natives by the Alaskan Claims Settlement Act, or some other comprehensive mechanism, Congress will on a by-case basis whether any particular program should be part of the the Federal-Hawaiian relationship. As Cohen has stated ". . . there is no reason to doubt that Congress has power to legislate specifically for the benefit of Native Hawaiians." [37]

FOOTNOTES

[1] The argument is based on applying considerations set out in Cohen's "Handbook of Federal Indian Law," infra, n. 8, that "singly or jointly, have been relied upon in reaching the conclusion that a group constitutes a tribe" of Indians. These include the treaties between the U.S. and Hawaii; recognition of Hawaiians as an aboriginal group in various Congressional Acts; collective rights in rights in land under the Hawaiian Homes Commission Act; and recognition of Hawaiian Natives an an aboriginal group by other Native groups. Contra, *Price* v. *State of Hawaii*, 764 F.2d 623 (9th Cir. 1985) applying recognition criteria to a specific Hawaiian entity.

[2] See, e.g. U.S. Congress, American Indian Policy Review Commission, Final report of the American Indian Policy Review Commission (Washington, D.C.: U.S. Government Printing Office, 1977)

[3] See *White* v. *Califano*, 437 F. Supp. 543 (D.S.D. 1977), aff'd 581 F.2d 697 (8th Cir. 1978) and *McNabb* v. *Heckler*, N. CU-83-051-GF (D. Mont. 1986).

[4] *Morton* v. *Mancari*, 417 U.S. 535 (1974).

[5] See e.g., *Fox* v. *Morton*, 505 F.2d 254 (9th Cir. 1974); *Vigil* v. *Andrus* 667 F. 2d 931 (10th Cir.. 1982); and *Wilson* v. *Watt* 703 F.2d 395 (10th Cir. 1983).

[6] But see, The Indian Health Care Improvement Act findings which state: ". . . health services to maintain and improve health of Indians are consonant with and required by the Federal government's historical and unique relationship with, and result in responsibility to, the American Indian people." 25 U.S.C. sec. 1601.

[7] The Hawaiian Study Commission majority report acknowledges a "very limited special trust" and the minority report argues for a broader trust. Either view would support rationally related services.

[8] 1982 Edition.

[9] Ibid, at 797-798.

[10] November 2, 1983 memorandum from the Congressional Research Service, Library of Congress, to Senator Daniel K. Inouye, "Definition of Native Hawaiians," at 1-2.

[11] 588 F.2d 1216 (9th Cir. 1978).

[12] Ibid, at 1226.

[13] The establishment of the Indian Claims Commission was in direct response to the inability to otherwise pursue claims.

[14] See e.g., Public Law 83-280 which permitted states to assume specified jurisdiction over Indians.

[15] Keaukaha-Panaewa Community Association v. Hawaiian Homes Commission, 739 F.2d 1467 (9th Cir. 1984).

[16] N. Levy, Native Hawaiian Land Rights, 63 Cal L. Rev 848 (1975) provides an extensive discussion of these matters and is relied upon throughout this paper.

[17] Treaty with Hawaii on Commerce, Dec. 23, 1826, United States-Hawaii, 3 C. Bevans, Treaties and Other Internal Agreements of the United States, 1776-1949, at 861 (1971).

[18] Treaty with Hawaii on Friendship, Commerce and Navigation, Dec. 20, 1849, U.S.-Hawaii, 9 Stat. 977.

[19] Treaty with Hawaii on Commercial Reciprocity, Jan. 30, 1875, U.S.-Hawaii, 19 Stat. 625.

[20] Treaty with Hawaii on Commercial Reciprocity, Dec. 6, 1884, U.S.-Hawaii, 25 Stat. 1399.

[21] Levy, supra, n.16 at 852.

[22] Ibid, at 853.

[23] Cohen, supra, n.8, at 800.

[24] James Blount was the former Chairman of the House of Representatives Committee on Foreign Affairs, appointed as Special Commissioner to Hawaii. See, Kuykendall, "The Hawaiian Kingdom, The Kalakaua Dynasty" (1967) for an in depth treatment of this era in Hawaiian affairs.

[25] President's Message Relating to the Hawaiian Islands, H.R. Exec. Doc. No. 47, 53d Cong., 2d Sess., XIV-XV (1895).

[26] S. Rep. No. 227, 53rd Cong., 2d Sess. (1893).

[27] 30 Stat. 750 (1898).

[28] Supra, n.8, at 802.

[29] 42 Stat. 108 (1921).
[30] H.R. Rep. No. 839, 66th Cong., 2d Sess. 4 (1920).
[31] P.L. 86–3, set out in full in 48 U.S.C. prec. sec. 491.
[32] See e.g., 16 U.S.C. sec. 396a (leases in Hawaii National Park); 21 U.S.C. sec. 1177(d) (National Institute on Drug Abuse); 42 U.S.C. sec. 1996 (Indian Religious Freedom Act); 42 U.S.C. sec 2991(a) (Administration for Native Americans); and similar legislation.
[33] *Morton* v. *Ruiz*, 415 U.S. 199, 231 (1974) "the power of an administrative agency to administer a congressionally created and funded program necessarily requires the formulation of policy and the making of rules to fill any gap left implicitly or explicitly by Congress."
[34] 25 C.F.R. 54.2.
[35] *Pence* v. *Kleppe*, 529 F.2d 135 (9th Cir. 1976).
[36] For example the importation of Reindeer for benefit of Alaskan Natives, 25 U.S.C. sec. 500.
[37] Supra, n. 8, at 803.

The analysis of the legal relationship between the United States government and Native Hawaiians was prepared by Paul Alexander, Attorney-at-Law.

LEGISLATIVE HISTORY

S. 2243 was introduced by Senator Inouye, for himself and Senators Andrews and Melcher on March 26, 1986, and was referred to the Select Committee on Indian Affairs. The Committee held a hearing on S. 2243 on May 7, 1986.

COMMITTEE RECOMMENDATIONS AND TABULATION OF VOTE

The Select Committee on Indian Affairs, in open business session on May 14, 1986, by a unanimous vote of quorum present, recommends that the Senate pass S. 2243, as amended.

COMMITTEE AMENDMENTS

The Committee recommends an amendment in the nature of a substitute.

SECTION-BY-SECTION ANALYSIS OF S. 2243

Section 1(1) sets forth the findings of the Congress that the Federal government retains the legal responsibility to enforce the administration of a public trust responsibility for the betterment of the conditions of Native Hawaiians by the State of Hawaii, as established in section 5(f) of Public Law 86–3, 73 Stat. 5 (1959).

Section 1(2) sets forth the findings of the Congress that in furtherance of the State of Hawaii's public trust responsibility for the betterment of the conditions of Native Hawaiians [section 5(f) of Public Law 86–3, 73 Stat. 5 (1959)] contributions by the Federal government to the provisions of health education and health services to maintain and improve the health status of Native Hawaiians are consistent with the historical and unique legal relationship of the Federal government with the government that represented the indigenous native people of Hawaii (the Native Hawaiian monarchy).

Section 1(3) sets forth the findings of the Congress that it is the policy of the Federal government to raise the health status of Native Hawaiians to the highest possible level and to encourage the maximum participation of Native Hawaiians in the planning and management of health services in order to achieve the objective of raising the health status of Native Hawaiians to the highest possible level.

Section 1(4) sets forth the findings of the Congress that Federal support for programs that provide health care to Native Hawaiians

has resulted in a reduction in the prevalence and incidence of preventable illnesses among Native Hawaiians and has resulted in a reduction in premature deaths of Native Hawaiians.

Section 1(5) sets forth the findings of the Congress that further improvement in the health status of Native Hawaiians is necessary on the basis of findings regarding the health status of Native Hawaiians that are contained in the report on Native Hawaiian Health Needs of the Department of Health and Human Services that was conducted by the Native Hawaiian Health Research Consortium and submitted to the Congress.

Section 2(1) sets forth the definition of the term "disease prevention" as used in the Act, to include: immunizations; control of high blood pressure; control of sexually transmittable diseases; prevention and control of diabetes and diabetes-related complications and illnesses; pregnancy and infant care, including prevention of fetal alcohol syndrome; control of toxic agents; occupational safety and health; accident prevention; flouridation of water; and control of infectious agents.

Section 2(2) sets forth the definition of the term "health promotion" as used in the Act, to include: cessation of tobacco smoking; reduction in the misuse of alcohol and drugs and inhalants; improvement of nutrition; improvement in physical fitness; family planning; and control and reduction of stress.

Section 2(3) sets forth the definition of the term "Native Hawaiian" as used in the Act, to mean any individual currently residing in the state of Hawaii who has any ancestors that were natives of the area that now comprises the state of Hawaii prior to 1778.

Section 2(4) sets forth the definition of the term "Native Hawaiian organization" as used in the Act, to mean any organization that serves and represents the interests of Native Hawaiians; that is recognized by the Office of Hawaiian Affairs of the state of Hawaii and E Ola Mau for the purpose of planning, conducting, or administering programs, or portions of programs, authorized by the Act; and in which Native Hawaiian health professionals significantly participate in the planning, management, monitoring, and evaluation of health services. The Office of Hawaiian Affairs was authorized in 1978, by an amendment to the Hawaii State Constitution (Section 5, Article 12). E Ola Mau is a non-profit organization of Native Hawaiian health care professionals and traditional Native Hawaiian health care providers. Section 2(4) anticipates that the Office of Hawaiian Affairs and E Ola Mau will certify to the Secretary of the Department of Health and Human Services, those Native Hawaiian organizations that fulfill the requirements of the definition contained in section 2(4) and that are eligible to enter into contracts with the Secretary.

Section 2(5) sets forth the definition of the term "Native Hawaiian educational institution" as used in the Act, to mean any educational institution that serves and represents the interests of Native Hawaiians, and which has as a primary and stated purpose the provision of educational services to Native Hawaiians. An example of such an educational institution is the Kemehameha Schools of the Bishop Estate.

Section 2(6) sets forth the definition of the term "Advisory Board" as used in the Act, to mean the Native Hawaiian Health

Promotion and Disease Prevention Advisory Board established under section 3(b) of the Act, and which is to consist of a representative from each of the following organizations: Alu Like, Inc.; the Office of Hawaiian Affairs of the state of Hawaii; E Ola Mau or any other organization composed of Native Hawaiian health care professionals; the University of Hawaii School of Medicine; the University of Hawaii School of Public Health; the University of Hawaii School of Nursing; the Hawaii State Department of Health; the Kamehameha Schools of the Bishop Estate; the Liliuokalani Trust; the Hawaii Nurses Association; the Hawaii Medical Association; the Hawaii State Department of Social Services and Housing; the Waianae Coast Comprehensive Health Center, or its successor organization, the Hawaii State Association of Community Health Centers; the Hawaii Psychological Association; the Hawaii Psychiatric Association; the Hawaii State Board of Education; the Department of Hawaiian Home Lands; the Hawaii Dental Association; and any other organization designated by the Secretary for the purpose of serving on the Advisory Board.

Section 2(7) sets forth the definition of the term "Secretary" as used in the Act, to mean the Secretary of the Department of Health and Human Services.

Section 3(a)(1) directs the Secretary of the Department of Health and Human Services, in consultation with the Native Hawaiian Health Promotion and Disease Prevention Advisory Board, to enter into contracts with Native Hawaiian organizations under which the Secretary is directed to provide funds to Native Hawaiian organizations to establish and administer programs of health promotion and disease prevention designed to serve Native Hawaiians, for fiscal year 1989 and for each fiscal year thereafter. Of the organizations desiring to enter into contracts with the Secretary under the authority of this section, the Office of Hawaiian Affairs of the state of Hawaii and the organization E Ola Mau, or its successor organization, shall certify to the Secretary which of such organizations are Native Hawaiian organizations. The Native Hawaiian Health Promotion and Disease Prevention Advisory Board shall then advise the Secretary as to the eligibility of designated Native Hawaiian organizations to enter into contracts with the Secretary.

It is contemplated that the Secretary would enter into a contract with a Native Hawaiian organization on the island of Oahu in the state of Hawaii for the purposes of establishing and administering a comprehensive health promotion and disease prevention program that would provide: (1) necessary preventive-oriented health services, including maternal and child health care and mental health care, through the establishment of community health centers; (2) the collection of data related to the prevention of diseases and illnesses among Native Hawaiians; (3) medical and general health-related research into the diseases that are most prevalent among Native Hawaiians; (4) research in the mental health problems that are most prevalent among Native Hawaiians; (5) education in health promotion and disease prevention; (6) health planning; and, (7) training for Native Hawaiian community health outreach workers as paraprofessionals in the provision of health care and health education. It is further contemplated that the Secretary would enter into contracts with Native Hawaiian organizations on the is-

lands of Maui, Kauai, Hawaii, Molokai, Lanai, and Niihau in the state of Hawaii for the purposes of establishing and administering a health promotion and disease prevention program on each island that would provide: (1) necessary preventive-oriented health care and mental health care, through the establishment of community health centers; (2) education in health promotion and disease prevention; and, (3) health planning.

Sections 3(a)(2) and 3(a)(2)(A) direct that the program to be established and administered under each contract entered into with the Secretary is to provide necessary preventive-oriented health services, including maternal and child health care and mental health care, through the establishment of community health centers, subject to the availability of appropriations authorized in section 4(a)(3)(B).

Section 3(a)(2)(B) further directs that the program to be established and administered under contract with the Secretary is to provide for the collection of data related to the prevention of diseases and illnesses among Native Hawaiians, including the prevention of fetal alcohol syndrome, hypertension, heart disease, and diabetes. It is anticipated that the collection of data, medical and mental health and general health-related research, as well as health planning, would be the primary activities undertaken in the initial phases of contract implementation.

Section 3(a)(2)(C) directs that the program to be established and administered under contract with the Secteray is to provide for medical and general health-related research into the diseases that are most prevalent among Native Hawaiians including, but not limited to, heart disease, hypertension, cancer and diabetes. It is anticipated that the collection of data, medical and mental health and general health-related research, as well as health planning, would be the primary activities undertaken in the initial phases of contract implementation.

Section 3(a)(2)(D) directs that the program to be establshed and administered under contract with the Secretary is to provide for research into the mental health problems that are most prevalent among Native Hawaiians including, but not limited to, alcoholism, substance abuse, reduction of stress, and child abuse. It is anticipated that the collection of data, medical and mental health and general health-related research, as well as health planning, would be the primary activities undertaken in the initial phases of contract implemention.

Section 3(a)(2)(E) directs that the program to be established and administrated under each contract entered into with the Secretary is to provide for education in health promotion and disease prevention in the Native Hawaiian population by Native Hawaiian community outreach workers and Native Hawaiian nurses.

Section 3(a)(2)(F) directs that the program to be established and administered under each contract entered into with the Secretary is to provide for health planning in areas which shall include, but not be limited to, health planning in maternal and child health, nutrition, disease prevention, health promotion, health education, and mental health. It is anticipated that the collection of data, medical and mental health and general health-related research, as

well as health planning, would be the primary activities undertaken in the initial phases of contract implementation.

Section 3(a)(2)(G) directs that the program to be established and administered under contract with the Secretary is to provide training for Native Hawaiian community health outreach workers as paraprofessionals in the provision of health care and health education in Native Hawaiian communities by means of a curriculum which: combines education in the theories of health care with supervised practical experience in the provision of health care; provides instruction and practical experience in health promotion and disease prevention activities, particularly nutrition, physical fitness, weight control, cessation of tobacco smoking, stress management, control of alcohol and substance abuse, including prevention of fetal alcohol syndrome, control of high blood pressure, prevention and control of diabetes, prevention of lifestyle related accidents, prenatal and postnatal infant health care, and maternal health care; and provides instruction in the most current and effective social, educational, and behavioral approaches to the establishment and maintenance of good health habits.

Section 3(b)(1) authorizes the establishment of the Native Hawaiian Health Promotion and Disease Prevention Advisory Board.

Section 3(b)(2)(A) directs that the Native Hawaiian Health Promotion and Disease Prevention Advisory Board is to be composed of: an individual appointed to the Advisory Board by the Secretary from among nominations submitted to the Secretary by the Governor of the state of Hawaii; and individuals representing each of the following organizations who are appointed to the Advisory Board by the Secretary from among nominations submitted by each of the following organizations: Alu Like, Inc.; the Office of Hawaiian Affairs of the state of Hawaii; E Ola Mau or any other organization composed of Native Hawaiian health care professionals and traditional Native Hawaiian health care providers; the University of Hawaii School of Medicine; the University of Hawaii School of Public Health; the University of Hawaii School of Nursing; the Hawaii State Department of Health; the Kamehameha Schools, Bernice Pauahi Bishop Estate; the Liliuokalani Trust; the Hawaii Nurses Association; the Hawaii Medical Association; the Hawaii State Department of Social Services and Housing; the Waianae Coast Comprehensive Health Center, or its successor organization, the Hawaii State Association of Community Health Centers; the Hawaii Psychological Association; the Hawaii Psychiatric Association; the Hawaii Social Work Association; the Hawaii Society of Public Health Educators; the Hawaii Dietetic Association; the Hawaii State Board of Education; the Department of Hawaiian Home Lands; the Hawaii Dental Association; and any other organization designated by the Secretary for purposes of serving on the Native Hawaiian Health Promotion and Disease Prevention Advisory Board.

Section 3(b)(2)(B)(i) provides that the term of office for each member of the Advisory Board shall be three years, except as provided in section 3(b)(2)(B)(ii).

Section 3(b)(2)(B)(ii)(I) provides that of the initial members of the Native Hawaiian Health Promotion and Disease Prevention Advisory Board, the member representing the Governor of the state of

Hawaii and the members representing Alu Like, Inc., the Office of Hawaiian Affairs of the state of Hawaii, E Ola Mau or any other organization composed of Native Hawaiian health care professionals and traditional Native Hawaiian health care providers, the University of Hawaii School of Medicine, the University of Hawaii School of Public Health, and the University of Hawaii School of Nursing shall have a term of three years.

Section 3(b)(2)(B)(ii)(II) provides that of the initial members of the Native Hawaiian Health Promotion and Disease Prevention Advisory Board, the members representing the Hawaii State Department of Health, the Kamehameha Schools, the Liliuokalani Trust, the Hawaii Nurses Association, the Hawaii Medical Association; the Hawaii State Department of Social Services and Housing; and the Waianae Coast Comprehensive Health Center, or its successor organization, the Hawaii State Association of Community Health Centers shall have a term of two years.

Section 3(b)(2)(B)(ii)(III) provides that of the initial members of the native Hawaiian Health Promotion and Disease Prevention Advisory Board, the members representing the Hawaii Psychological Association, the Hawaii Psychiatric Association, the Hawaii Social Work Association, the Hawaii Society of Public Health Educators, the Hawaii Dietetic Association, the Hawaii State Board of Education, the Department of Hawaiian Home Lands, the Hawaii Dental Association, and any other organization designated by the Secretary to serve on the Advisory Board shall have a term of one year.

Section 3(b)(2)(C) provides that a vacancy on the Advisory Board shall be filled in the same manner in which the original appointment was made, and that an appointed member shall serve for the remainder of the term of office to which the member is appointed.

Section 3(b)(2)(D) provides that to the extent feasible, individuals nominated for and appointed to the Advisory Board should be Native Hawaiians.

Section 3(b)(2)(E) provides that the members of the Advisory Board are to elect a chairman from among the members of the Board.

Section 3(b)(3) sets forth the responsibilities of the Advisory Board as overseeing: the awarding of contracts under section 3(a)(1), the administration of programs for which contracts are entered into under section 3(a)(1), and grants awarded under section 3(c); and preparing and submitting to the Secretary reports for each calendar quarter on the oversight conducted under subparagraph (A); and preparing and submitting to the Congress, through the Secretary, annual reports containing recommendations on activities that are designed to address the health care needs of Native Hawaiians, and that may be conducted by the state of Hawaii, the Federal government, community health centers, Native Hawaiian organizations, or private health care providers.

Section 3(b)(4) directs that the provisions of section 14 and subsections (3) and (f) of section 10 of the Federal Advisory Committee Act are not to apply with respect to the Advisory Board.

Section 3(c)(1) provides that subject to the availability of funds appropriated under the authority of section 3(c)(3), the Secretary shall provide grants to Native Hawaiian organizations for the purpose of developing the management capabilities of such organiza-

tions to plan and operate the health promotion and disease prevention programs that are to be established under contracts entered into under the authority of section 3(a).

Section 3(c)(2) provides that the total amount of grants that may be made to any Native Hawaiian organization under section 3(c)(1) shall not exceed $75,000.

Section 3(c)(3) authorizes appropriations of $600,000 for fiscal year 1987, and for each fiscal year thereafter, for the purpose of funding grants under section 3(c)(1).

Section 3(d)(1) authorizes the Secretary to enter into an agreement with any Native Hawaiian organization or any Native Hawaiian educational institution to assign personnel of the Department of Health and Human Services with expertise identified by the Native Hawaiian organization or Native Hawaiian educational institution, on detail for the purpose of providing education in health promotion and disease prevention to underserved Native Hawaiian children. For purposes of this section, underserved Native Hawaiian children are those children that are not currently receiving health promotion and disease prevention education.

Section 3(d)(2) provides that the assignment of personnel by the Secretary under an agreement entered into under the authority of section 3(d)(1) is to be treated as an assignment of Federal personnel to a local government that is made in accordance with subchapter VI of chapter 33 of title 5, United States Code.

Section 3(e)(1) directs the Secretary to establish a Native Hawaiian Program for Health Promotion and Disease Prevention as a demonstration project in the state of Hawaii for the purpose of exploring ways to meet the unique health care needs of Native Hawaiians.

Section 3(e)(2) provides that the demonstration project that is to be established under the authority of section 3(e)(1) is to provide necessary preventive-oriented health services, including health education and mental health care; develop innovative training and research projects; establish cooperative relationships with the leadership of the Native Hawaiian community; and ensure that a continuous effort is made to establish programs that can be of direct benefit to other Native American people. The demonstration program is intended to provide an experiential basis for the later establishment of the more comprehensive health promotion and disease prevention program that is authorized in section 3(a)(2).

Section 3(e)(3) authorizes the Secretary to enter into contracts with Native Hawaiian organizations for the purpose of assisting the Secretary in meeting the objectives of the demonstration program that is to be established under section 3(e)(1).

Section 3(e)(4) directs the Secretary to submit an annual report to the Congress on the status and accomplishments of the demonstration program during each of the fiscal years 1987, 1988, and 1989.

Section 3(e)(5) authorizes appropriations in the amount of $500,000 for each of the fiscal years 1987, 1988, and 1989, for the purpose of funding the establishment of the demonstration program and activities directed to be carried out by the demonstration program.

Section 3(f)(1) directs the Secretary to include in any contract which the Secretary enters into with any Native Hawaiian organization under the authority of section 3, such conditions as the Secretary considers necessary to ensure that the objectives of the contract are achieved.

Section 3(f)(2) directs the Secretary to develop procedures to evaluate complance with and performance of contracts entered into by Native Hawaiian organizations under the authority of section 3.

Section 3(f)(3) directs the Secretary to conduct an annual onsite evaluation of each Native Hawaiian organization that has entered into a contract under the authority of section 3 for purposes of determining the compliance of each organization with the contract and for the purpose of evaluating the performance of each organization under the contract.

Section 3(f)(4) provides that if as a result of the evaluations conducted under the authority of section 3(f)(3), the Secretary determines that a Native Hawaiian organization has not complied with or satisfactorily performed a contract entered into under section 3, the Secretary is directed to attempt to resolve the areas of noncompliance or unsatisfactory performance prior to renewing the contract, and if necessary, modify the contract to prevent future occurrences of such noncompliance or unsatisfactory performance. If the Secretary determines that the noncompliance. If the Secretary determines that the noncompliance or unsatisfactory performance cannot be resolved or prevented in the future, the Secretary is directed not to renew the contract with the Native Hawaiian organization and is authorized to enter into a contract under the authority of section 3 with another Native Hawaiian organization which serves the same population of Native Hawaiians that is served by the Native Hawaiian organization whose contract is not renewed.

Section 3(f)(5) provides that in determining whether to renew a contract entered into with a Native Hawaiian organization under section 3, the Secretary is directed to review the records of the Native Hawaiian organization and the reports submitted by the Advisory Board under the authority of section 3(b)(3)(B) with respect to the organization; and to consider the results of the onsite evaluations conducted under section 3(f)(3).

Section 3(f)(6) provides that all contracts entered into by the Secretary under the authority of section 3 are to be in accordance with all Federal contracting laws and regulations except that in the discretion of the Secretary, contracts may be negotiated without advertising and need not conform to the provisions of the Act of August 24, 1935, 40 U.S.C. 270a, et seq.

Section 3(f)(7) provides that payments made under any contract entered into under the authority of section 3 may be made in advance by means of reimbursement or in installments, and are to be made on such conditions as the Secretary deems necessary to carry our the purpose of section 3.

Section 3(f)(8) provides that notwithstanding any other provision of law, the Secretary may, at the request or consent of a Native Hawaiian organization, revise or amend any contract entered into by the Secretary with the organization under the authority of section 3, except that whenever the organization requests retrocession of any contract entered into under the authority of section 3, the

retrocession shall become effective upon a date specified by the Secretary that is not more than 120 days after the date of the request by the organization or at such later date as may be mutually agreed to by the Secretary and the organization. Upon retrocession of the contract, the Secretary may enter into a contract under the authority of section 3 with another Native Hawaiian organization which serves the same population of Native Hawaiians that is served by the Native Hawaiian organization that has requested retrocession of the contract. If there is no other Native Hawaiian organization with which the Secretary may enter into a contract, the Secretary is not obligated to carry out the activities that would have been performed pursuant to the terms of the contract.

Section 3(f)(9)(A) provides that for each fiscal year during which a Native Hawaiian organization receives or expends funds pursuant to a contract entered into under the authority of section 3, the Native Hawaiian organization is to submit a quarterly report to the Secretary on the activities conducted by the organization under the contract; the amounts and purposes for which Federal funds were expended; and any other information as the Secretary may request.

Section 3(f)(9)(B) provides that the reports and records of any Native Hawaiian organization that concern any contract entered into under the authority of section 3 are to be subject to audit by the Secretary and the Comptroller General of the United States.

Section 3(f)(10) directs that the Secretary is to allow as a cost of any contract entered into under the authority of section 3, the cost of an annual private audit conducted by a certified public accountant.

Section 3(f)(11) provides that the authority of the Secretary to enter into contracts under the authority of section 3 is to be to the extent, and in amounts, provided for in appropriation acts of the Congress.

Section 4(a)(1)(A) authorizes the Secretary to designate native Hawaiians as a medically underserved population for purposes of section 330 of the Public Health Service Act, 42 U.S.C. 254c.

Section 4(a)(1)(B) authorizes the Secretary to provide planning grants to Native Hawaiian organizations, or to any organization of health care professionals serving Native Hawaiians, for the purpose of planning community health centers to serve the health needs of Native Hawaiian communities, provided that there shall be no more than eight such grants, and that each grant shall not exceed $100,000.

Section 4(a)(1)(C) authorizes the Secretary to establish community health centers under section 330 of the Public Health Service Act to serve the health needs of Native Hawaiian communities.

Section 4(a)(2) directs the Secretary to consult with the Governor of the state of Hawaii regarding any grants that the Secretary may make under the authority of section 330(c)(1) of the Public Health Service Act, 42 U.S.C. 254c(c)(1), or under section 4(a)(1)(B), for the planning and developing of community health centers to serve the health needs of Native Hawaiian communities.

Section 4(a)(3) provides that in addition to any other amounts that are authorized to be appropriated for carrying out section 330 of the Public Health Service Act, there are authorized to be appro-

priated for fiscal year 1987, $800,000 for the purpose of providing planning grants authorized under section 4(a)(1)(B), and $2,800,000 for the purpose of establishing under section 330 of the Public Health Service Act no more than eight community health centers to serve the health needs of Native Hawaiian communities, provided that such sums are to remain available until expended, without fiscal year limitation, and provided that no more than $350,000 of the funds authorized for the purpose of establishing community health centers may be expended for each community health center.

Section 4(b) authorizes the Secretary to designate Native Hawaiians as a population group which has a health manpower shortage for purposes of subpart II of part C of title III of the Public Health Service Act.

Section 5(a) provides that subject to the availability of funds appropriated under the authority of section 5(c), the Secretary is directed to provide scholarship assistance to students who meet the requirements of section 338A(b) of the Public Health Service Act, 42 U.S.C. 2541(b), and are Native Hawaiians.

Section 5(b) requires that the scholarship assistance provided under section 5(a) is to be provided under the same terms and subject to the same conditions, regulations, and rules that apply to scholarship assistance provided under section 338A of the Public Health Service Act, 42 U.S.C. 2541.

Section 5(c) authorizes appropriations in the amount of $1,800,000 for fiscal year 1987, and for each fiscal year thereafter, for the purpose of funding the scholarship assistance provided under section 5(a).

Section 6(a)(1) directs the Secretary to enter into contracts with Native Hawaiian organizations for the provision of health care referral services for Native Hawaiians. The section directs that such contracts are to include requirements that the Native Hawaiian organization successfully undertake to determine the population of Native Hawaiians who are or could be recipients of health care referral services; determine the current health status of Native Hawaiians served by the Native Hawaiian organization; determine the current health care needs of Native Hawaiians served by the Native Hawaiian organization; identify all public and private health services resources which are or could be available to Native Hawaiians; determine the use of public and private health services resources by Native Hawaiians; assist such health services resources in providing services to Native Hawaiians; assist Native Hawaiians in becoming familiar with such health services resources and in utilizing such health services resources; provide basic health education to Native Hawaiians, including education in health promotion and disease prevention through a community health outreach program that uses Native Hawaiian community health outreach workers; establish and implement manpower training programs to accomplish referral and education tasks; identify any disparity between the health needs of Native Hawaiians that are not being met and the resources available to meet such needs; and make recommendations to the Secretary and Federal, state, local, and other resource agencies on methods of improving health service programs to meed the needs of Native Hawaiians.

Section 6(a)(2) directs the Secretary to prescribe regulations that provide the criteria for selecting Native Hawaiian organizations to enter into contracts under the authority of section 6(a)(1) and directs that the criteria are to include among other factors: the extent of the health care needs of Native Hawaiians served by the Native Hawaiian organization that are not being met; the size of the Native Hawaiian population served by the Native Hawaiian organization; the accessibility to and utilization of health care services by Native Hawaiians served by the Native Hawaiian organization; the extent if any to which the activities that are required to be undertaken under section 6(a)(1) would duplicate any previous or current public or private health services project that was, or is funded by any means other than a contract entered into under the authority of section 6(a)(1) or any project funded by means of a contract entered into under the authority of section 6(a)(1); the capability of the Native Hawaiian organization to perform the activities that are required to be undertaken under section 6(a)(1) and enter into a contract with the Secretary under section 6(a)(1); the satisfactory performance and successful completion by the Native Hawaiian organization of other contracts entered into with the Secretary under section 6(a)(1); the appropriateness and likely effectiveness of conducting the activities that are required to be undertaken under section 6(a)(1); and the extent of existing participation or likely future participation in the activities that are required to be undertaken under section 6(a)(1) by appropriate health and health-related Federal, state, local, and other agencies.

Section 6(b)(1) authorizes the Secretary to enter into contracts with Native Hawaiian organizations that have not entered into a contract with the Secretary under the authority of section 6(a)(1), for the purpose of determining the matters described in section 6(b)(2) in order to assist the Secretary in assessing the health status and health care needs of Native Hawaiians served by the Native Hawaiians organization, and whether the Secretary should enter into a contract under section 6(a)(1) with the Native Hawaiian organization.

Section 6(b)(2) provides that any contract entered into by the Secretary under the authority of section 6(b)(1) is to include requirements that the Native Hawaiian organization document the health care status and health care needs of Native Hawaiians served by the Native Hawaiian organization; determine the matters described in section 6(a)(2) (B), (C), (D), and (H) with respect to Native Hawaiians served by the Native Hawaiian organization; and complete performance of the contract within one year after the date on which the Secretary and the Native Hawaiian organization enter into such contract.

Section 6(c)(1) directs the Secretary to include in any contract entered into under the authority of section 6(b)(1) with a Native Hawaiian organization, such conditions as the Secretary considers necessary to encourage the establishment of programs that make health care servcies more accessible to Native Hawaiians.

Section 6(c)(2) directs the Secretary to develop procedures to evalaute compliance with and performance of contracts by Native Hawaiian organizations entered into under the authority of section

6(b)(1), and provides that such procedures are to include provisions for carrying out the requirements of section 6(c)(1).

Section 6(c)(3) directs the Secretary to conduct an annual onsite evaluation of each Native Hawaiian organization that has entered into a contract under section 6(a) for purposes of determining the compliance of a Native Hawaiian organization with the terms of the contract and evaluating the performance of a Native Hawaiian organization under the contract.

Section 6(c)(4) provides that if as a result of the evaluations conducted under section 6(c)(3), the Secretary determines that a Native Hawaiian organization has not complied with or satisfactorily performed a contract entered into under section 6(a), the Secretary is to attempt to resolve the areas of noncompliance or unsatisfactory performance prior to renewing the contract, and modify the contract to prevent future occurrences of noncompliance or unsatisfactory performance. Section 6(c)(4) also provides that if the Secretary determines that the noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary is not to renew the contract with a Native Hawaiian organization and is authorized to enter into a contract under the authority of section 6(a) with another Native Hawaiian organization which serves the same population of Native Hawaiians that is served by the Native Hawaiian organization whose contract is not renewed by reason of section 6(c)(4).

Section 6(c)(5) provides that in determining whether to renew a contract entered into with a Native Hawaiian organization under the authority of section 6(a), or whether to enter into a contract with a Native Hawaiian organization under section 6(a) that has completed performance of a contract entered into under the authority of section 6(b), the Secretary is to review the records of the Native Hawaiian organization and the reports submitted under section 6(e), and in the case of a renewal of a contract entered into under the authority of section 6(a), the Secretary is to consider the results of the onsite evaluations conducted under section 6(c)(3).

Section 6(d)(1) provides that no contract entered into under section 6 may provide for a total amount of payments under the contract by the Federal government that exceeds $125,000.

Section 6(d)(3) provides that payments made under any contract entered into under the authority of section 6 may be made in advance, by means of reimbursement, or in installments, and are to be made on such conditions as the Secretary deems necessary to carry out the purposes of section 6.

Section 6(d)(4) provides that notwithstanding any other provision of law, the Secretary is authorized to revise or amend any contract entered into under the authority of section 6 by the Secretary with a Native Hawaiian organization at the request of or with the consent of the Native Hawaiian organization as necessary to carry out the purposes of section 6, except that whenever a Native Hawaiian organization requests retrocession of any contract entered into under the authority of section 6, the requested retrocession is to become effective upon a date specified by the Secretary that is not more than 120 days after the date of the request by the Native Hawaiian organization or at such later date as may be mutually agreed to by the Secretary and the Native Hawaiian organization.

Upon retrocession of the contract, the Secretary may enter into a contract under the authority of section 6 with another Native Hawaiian organization which serves the same population of Native Hawaiians that is served by the Native Hawaiian organization that has requested retrocession of the contract. If there is no other Native Hawaiian organization with which the Secretary may enter into a contract, the Secretary is not obligated to carry out the activities of that would have been performed pursuant to the terms of the contract.

Section 6(d)(5) provides that all contracts entered into under the authority of section 6, are to include provisions to assure the fair and uniform provision to Native Hawaiians of health care referral services and assistance under section 6 contracts by Native Hawaiian organizations.

Section 6(e)(1) provides that for each fiscal year during which a Native Hawaiian organization receives or expends funds pursuant to a contract entered into under the authority of section 6, the Native Hawaiian organization is required to submit to the Secretary a quarterly report on: disparities identified and recommendations made under section 6(a)(1) (J) and (K), in the case of a contract entered into under the authority of section 6(b); activities conducted by the Native Hawaiian organization under the contract; the amounts and purposes for which Federal funds were expended; and, any other information that the Secretary may request.

Section 6(e)(2) provides that the reports and records of any Native Hawaiian organization that concern any contract entered into under the authority of section 6 are to be subject to audit by the Secretary and the Comptroller General of the United States.

Section 6(e)(3) directs the Secretary to allow as a cost of any contract entered into under the authority of section 6(a), the cost of an annual private audit conducted by a certified public accountant.

Section 6(f)(1) provides that the authority of the Secretary to enter into contracts under the authority of section 6 is to be to the extent, and in an amount provided for in appropriations acts of Congress.

Section 6(f)(2) authorizes appropriations in the amount of $625,000 for fiscal year 1987, and for each fiscal year thereafter, for the purpose of funding contracts entered into under the authority of section 6.

Section 7(a) directs the Secretary to conduct a study of any barriers that may exist to the participation of Native Hawaiians in programs established under title XVIII of the Social Security Act (Medicare) or under title XIX of the Social Security Act (Medicaid) in consultation with Native Hawaiian organizations.

Section 7(b) directs the Secretary to submit to the Congress a report on the study conducted under the authority of section 7(a) by no later than the date that is one year after the date of enactment of this Act, and requires that the report include; recommendations for legislation that would remove any barriers to participation identified in the section 7(a) study, and which would encourage participation by Native Hawaiians in the programs described in section 7(a); and estimates of the potential number of Native Hawaiians eligible for Medicare, the potential number of Native Hawaiians eligible for Medicaid, the number of Native Hawaiians par-

ticipating in the Medicare program, and the number of Native Hawaiians participating in the Medicaid program.

Section 8 authorizes the appropriations of such sums as may be necessary to carry out the provisions of this Act for fiscal year 1987 and for each fiscal year thereafter for which a specific authorization for appropriations is not otherwise provided for in this Act.

COST AND BUDGETARY CONSIDERATIONS

The cost estimate for S. 2243, as amended, as evaluated by the Congressional Budget Office, is set forth below:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, May 22, 1986.

Hon. MARK ANDREWS,
Chairman, Select Committee on Indian Affairs,
U.S. Senate, Washington, DC

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for S. 2243, as ordered reported on May 14, 1986.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,

Sincerely,

RUDOLPH G. PENNER, *Director.*

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill No. S. 2243.
2. Bill title: None.
3. Bill status: As ordered reported on May 14, 1986.
4. Bill purpose: To improve the health status of Native Hawaiians, and for other purposes.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1987	1988	1989	1990	1991
Estimated authorization levels:					
Management grants	0.6	0.6	0.6	0.6	0.6
Demonstration project	.5	.5	.5		
Scholarships	1.8	1.8	1.8	1.8	1.8
Health care referral	.6	.6	.6	.6	.6
Planning grants	.8	.8	.9	.9	1.0
Community health centers	2.8	3.0	3.1	3.3	3.5
Advisory board	.4	.4	.5	.5	.5
HPDP program			9.9	10.1	10.9
Education	.3	.3	.3	.4	.4
Study	.3				
Total estimated authorization level	8.1	8.0	18.2	18.2	19.3
Total estimated outlays	4.6	7.0	13.5	16.7	18.3

Note: The costs of this bill fall within function 550.

Basis of estimate: Specific authorization levels for management grants, the demonstration project, scholarships, health care referral, and the first year costs of planning and establishing communi-

ty health centers are stated in the bill. S. 2243 authorizes such sums as may be necessary to carry out all remaining provisions. Activities authorized in the bill without stated levels for authorizations of appropriations have been estimated by CBO. CBO assumes all authorized amounts are fully appropriated at the beginning of each fiscal year. Outlays are estimated on the basis of similar health service program data. All authorization levels are subject to subsequent appropriations action.

Authorization levels for planning future community health centers and for establishing up to eight new centers are stated in the bill for fiscal year 1987 only. Future years' authorizations are estimated by increasing the stated amounts by the projected rate of inflation for health services.

Costs for the advisory board have been estimated assuming all 20 members would be compensated when engaged in the actual duties of the Board. Costs also include salary and overhead for three staff people we assume would be needed to fulfill the duties of the Board.

The HPDP program would have four basic functions that CBO estimates would result in additional costs to the federal government: data collection, research, health planning, and community outreach. CBO estimates the total cost of the HPDP program to be between $10 and $11 million in fiscal years 1989 through 1991. Bill language concerning HPDP program implementation is not specific. Costs for this program could vary depending on exactly how the program is implemented.

As part of the HPDP program the bill authorizes data collection on disease prevention among Native Hawaiians. The federal government currently operates a similar system that collects and analyzes data on smoking at a cost of about $2 million each year. Similar costs could be expected to result from disease prevention data collection. The program would also provide for research into diseases and mental health problems most prevalent among Native Hawaiians. CBO assumes three researchers would be supported every year at a total annual cost of $450,000. This estimate is based on the average annual research award of $150,000 provided by the National Institutes of Health. Education in health promotion and disease prevention in the Native Hawaiian population would be provided by community outreach workers and native Hawaiian nurses at a negligible additional cost to the federal government.

Health planning activities authorized as part of the HPDP program might be accomplished by establishing a main health planning board consisting of five members with an additional health planner on each of the seven Hawaiian islands. This type of health planning board would cost just more than $1 million in each fiscal year. The bill authorizes the HPDP programs to employ Native Hawaiian community health outreach workers and train them as paraprofessionals in the provision of health care and health education. Assuming ten workers were employed at each of the eight HPDP sites and that workers were trained to the level of certification of medical assistants, costs for salaries, overhead and training could range from $6.0 to $6.4 million in fiscal years 1989 through 1991.

Another section of the bill authorizes the Secretary of Health and Human Services (HHS) to assign personnel on detail to Native Hawaiian oraganization educational institutions to provide health promotion and disease prevention education. There is one central Native Hawaiian educational institution and 28 Native Hawiian education programs in outlying areas. If four employees were assigned on detail, about $300,000 for salary and overhead would be redirected in each fiscal year from HHS's current activities to health promotion and disease prevention education in Hawaii.

Costs for the study on access to Medicare and Medicaid services are estimated to be $300,000 in fiscal year 1987 only.

6. Estimated cost to State and local government: The budgets of state and local governments would not be affected directly by the enactment of this legislation.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Carmela Dyer.

10. Estimate approved by: James L. Blum, Assistant Director for Budget Analysis.

REGULATORY IMPACT STATEMENT

Paragraph 11(b) of rule XXVI of the Standing Rules of the Senate requires each report accompanying a bill to evaluate the regulatory and paperwork impact that would be incurred in carrying out the bill. The Committee believes that S. 2243, as amended, will have a minimal impact on regulatory or paperwork requirements.

EXECUTIVE COMMUNICATIONS

The Committee received testimony on S. 2243 from the Department of Health and Human Services. The Department's statement is set forth below:

STATEMENT OF SAMUEL LIN, M.D., PH.D. DEPUTY ASSISTANT SECRETARY FOR HEALTH, (INTERGOVERNMENTAL AFFAIRS), U.S. PUBLIC HEALTH SERVICE BEFORE THE SENATE SELECT COMMITTEE ON INDIAN AFFAIRS, U.S. SENATE, MAY 7, 1986

Mr. Chairman: It is a pleasure for me to appear before you to discuss the health of Native Hawaiians and the proposed Senate bill 2243.

Let me start by assuring you that the Public Health Service [PHS] continues to work closely with the Hawaii Department of Health and other health providers to advance the health of all Hawaiians. We believe that the State of Hawaii has one of the finest departments of health in this country and the statistics of the Hawaiian people will attest to that fact. The residents of Hawaii have the highest life expectancy in the country and the lowest infant mortality rates.

The PHS is opposed to Senate bill 2243 because it would lessen the responsibility of the Hawaiian government for its own people and further remove the decision-making from the local communities.

We believe that the recently formed Native Hawaiian Health Planning Advisory Committee and the concomitant development of the e ola mau or the preliminary plan for improving native Hawaiian health through health promotion, disease prevention and health protection is a more constructive approach to raising the level of health status of native Hawaiians and to encourage their maximum participation in the planning and management of their own health services.

Mr. Chairman, aside from our other objections to Senate bill 2243, we believe that the provisions dealing with community health centers [CHC's] and National Health Service Corps [NHSC] scholarships are unnecessary and redundant.

The authority to designate medically underserved population already exists in section 330 of the PHS Act. It is not necessary to re-state that authority for native Hawaiians. In fact, we have already designated fourteen (14) medically underserved areas in Hawaii.

The authority to fund new CHC's also is contained in section 330, and we do make such awards within the limits of available resources. Awards are made to community-based systems of care which demonstrate the ability to provide access to medically underserved populations. These systems must have effective clinical operations and efficient administration and management.

Similarly, the authority to designate populations as having a health manpower shortage exists in section 332 of the PHS Act. Designation is based on the ratio of available health manpower to the number of individuals in the area or population, and on the indicators of need such as infant mortality and poverty. There are currently two (2) primary care health manpower shortage areas designated in Hawaii.

There are several student assistance programs available for Hawaiians who wish to pursue health careers including health education assistance loans, health professions student loans, and nursing student loans.

In summary, we believe that the intent of the proposed legislation can be best accomplished with existing authorities and programs and by placing the responsibility for the health of Native Hawaiians with themselves, with their own communities and with the State of Hawaii.

Mr. Chairman, this concludes my prepared statement and I will be happy to answer any questions.

CHANGES IN EXISTING LAW

In compliance with subsection 12 of rule XXVI of the Standing Rules of the Senate, it is the opinion of the Committee that it is necessary to dispense with the requirements of this subsection to expedite the business of the Senate.

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